CENTER FOR PEDIATRIC BEHAVIORAL HEALTH

EARLY SKILL ACQUISITION PROGRAM SCREENING FORM

Instructions:
Please complete and submit this screening form to schedule an appointment for an evaluation. You may submit this completed form to:

E-mail: info@centerforpbh.com
Fax: 910-660-8199
Mail: Center for Pediatric Behavioral Health
Early Skill Acquisition Program Intake
720 St. James Drive
Wilmington, NC 28403

A staff member will contact you to gather additional information and/or schedule an evaluation after you complete and submit the screening form. Submitting an incomplete screening form will result in delays to scheduling formal evaluations.

You will need to bring the following additional information to the scheduled evaluation.

1. Your child's most recent medical evaluation and medical records.
2. Records of therapy (previous and current) for your child.
3. Any documents related to services being received such as past intervention reports, Individualized Education Program (IEP), or other relevant documents.

If you have any questions or need assistance, please call 910-660-8200 or email info@centerforpbh.com.

BIOGRAPHICAL

Child's Name: _____ Date of Birth: _____

Caregiver/Legal Guardian #1

Name: _____

Address: _____

City, State, Zip: _____

Telephone: _____ (Home) _____ (Work)

_____ (Cell)

Caregiver/Legal Guardian #2

Name: _____

Address: _____

City, State, Zip: _____

Telephone: _____ (Home) _____ (Work)

_____ (Cell)

Who lives in the home?

_____

_____

CURRENT MEDICAL PROVIDERS AND SCHOOL INFORMATION

Name of Primary Care Physician: _____

Affiliation: _____

Address: _____

Telephone: _____

Name of Teacher: _____

School: _____

Address: _____

Telephone: _____

PRIOR PROFESSIONAL CONTACTS

Please list all past and current therapies your child has received by completing each of the boxes below.

Service	Start/End Date (Month/ Year)	How Often?	Length of each therapy session	What goals were being addressed?	Effect of therapy for feeding problem	Therapist Information (Name, address, telephone)
Occupational Therapy ☐ Yes ☐ No		☐ 1x/month ☐ 2x/month ☐ 1x/week ☐ 2x/week ☐ 3x/week ☐ _____	☐ 15 min ☐ 30 min ☐ 45 min ☐ 1 hr ☐ 1.5 hrs ☐ _____		☐ Worse ☐ No change ☐ Improved	
Physical Therapy ☐ Yes ☐ No		☐ 1x/month ☐ 2x/month ☐ 1x/week ☐ 2x/week ☐ 3x/week ☐ _____	☐ 15 min ☐ 30 min ☐ 45 min ☐ 1 hr ☐ 1.5 hrs ☐ _____		☐ Worse ☐ No change ☐ Improved	
Speech ☐ Yes ☐ No		☐ 1x/month ☐ 2x/month ☐ 1x/week ☐ 2x/week ☐ 3x/week ☐ _____	☐ 15 min ☐ 30 min ☐ 45 min ☐ 1 hr ☐ 1.5 hrs ☐ _____		☐ Worse ☐ No change ☐ Improved	
Early Intervention ☐ Yes ☐ No		☐ 1x/month ☐ 2x/month ☐ 1x/week ☐ 2x/week ☐ 3x/week ☐ _____	☐ 15 min ☐ 30 min ☐ 45 min ☐ 1 hr ☐ 1.5 hrs ☐ _____		☐ Worse ☐ No change ☐ Improved	
Others: (please list)		☐ 1x/month ☐ 2x/month ☐ 1x/week ☐ 2x/week ☐ 3x/week ☐ _____	☐ 15 min ☐ 30 min ☐ 45 min ☐ 1 hr ☐ 1.5 hrs ☐ _____		☐ Worse ☐ No change ☐ Improved	

MEDICAL INFORMATION

Birth History

How many weeks pregnant were you when your child was born? _____

Was your child born by vaginal delivery or C-section? _____

What was your child's birth weight/length? _____ lbs_____inches

Were there any problems at birth? _____

Were there any problems during pregnancy? _____

Medical History

Current Diagnoses: _____

At what age did your child receive each diagnosis: _____

Who provided the diagnosis: _____

Previous Illnesses: _____

Most recent hearing screen: _____; Results: _____

Most recent vision screen: _____; Results: _____

Past surgeries/hospitalizations: _____

History of any of the following? (Check all that apply):

☐ Seizures ☐ Diabetes ☐ Asthma ☐ Constipation (frequent)

☐ Vision problems ☐ Hearing Problems ☐ Sleep Problems

Describe all checked items above:

_____

_____

Current medications and dosages:

_____

_____

Allergies: Medications/Environmental/Seasonal: _____

Food Allergies: _____

Food Intolerance? (e.g. lactose intolerance): _____

Are immunizations up-to-date: _____

If not up-to-date, what is delinquent? _____

Any foods avoided intentionally by the family? _____

Does your child have any health-related restrictions regarding exercise?

Current height: ____ feet, ____ inches

Current weight: _____ lbs

At what age did your child: **DEVELOPMENTAL HISTORY**

Roll over: _____

Sit independently: _____

Take first steps: _____

Play games (like peek-a-boo): _____

Crawl: _____

Smile: _____

Babble: _____

Use single words: _____

Use short phrases: _____

Use sentences: _____

Toilet trained during day: _____

Toilet trained at night: _____

As an infant/toddler, was your child:

- ☐ Interested in people
- ☐ Overly active
- ☐ Easy to please
- ☐ Irritable/Cranky
- ☐ Difficult to nurse or feed
- ☐ Interested in toys
- ☐ Underactive
- ☐ Able to be flexible
- ☐ Difficult to soothe
- ☐ Resistant to touch
- ☐ Reactive to certain noises

SLEEP SCHEDULE

Check any that describe your child.

- ☐ Has difficulty going to sleep at night
- ☐ Tantrums when put to bed
- ☐ Has other behavior problems when put to bed
- ☐ Has difficulties going to sleep during naps
- ☐ Has difficulties staying asleep
- ☐ Has difficulties staying in bed
- ☐ Wants to sleep in caregiver's bed

My child goes to bed at _____ pm.

My child wakes up at _____ am.

My child takes a nap from _____ to _____ and _____ to _____.

COMMUNICATION

What is your child's primary form of communication?

☐ Gestures ☐ Picture Exchange ☐ Sign Language ☐ Vocal Language ☐ Other_____

How does your child request items?

_____

_____

Does your child… (Select Yes or No)

Respond to his/her name?

Imitate words/sounds you say? Example_____

Imitate words/sounds from his/her favorite videos? Example_____

Label things that he/she sees? Example_____

Label things that he/she feels? Example_____

Label things that he/she smells? Example_____

Label things that he/she hears? Example_____

About how many different things can your child label? _____

Does your child… (Select Yes or No)

Follow one step directions? Example_____

Follow two or more step directions? Example_____

Respond to questions? Example_____

About how many questions can your child respond? _____

Tell you what happened during the day? Example_____

How many different words does your child say in a 30-minute period? _____

ADAPTIVE SKILLS

Check one that best describes your child's mental abilities.

☐ Normal Intelligence ☐ Mild ID ☐ Moderate ID

☐ Severe ID ☐ Profound Intellectual Disability (ID)

Does your child… (Select Yes or No)

Feed self	Look you in the eye when you are talking
Dress self	Makes eye contact when pointing
Help with household chores	Point to things from 3 feet away or more
Tie shoes	Play with toys the same way
Walk up/down stairs	Play with a limited number of toys
Stay near in public places	Play with toys appropriate (hit nails with hammer)
Imitate things you do	Play with toys imaginatively (use box as phone)
Talk to peers	Plays with toys next to others

OTHER BEHAVIOR PROBLEMS

Does your child have any other behaviors that you think are a problem? Check any one that describes your child's behavior.

Behavior	Occurs	Frequency
Temper tantrums	☐	____ times per ☐ hour ☐ day ☐ week ☐ month
Argues	☐	____ times per ☐ hour ☐ day ☐ week ☐ month
Hurts self	☐	____ times per ☐ hour ☐ day ☐ week ☐ month
Hurts other people	☐	____ times per ☐ hour ☐ day ☐ week ☐ month
Complains of aches or pains	☐	____ times per ☐ hour ☐ day ☐ week ☐ month
Throws or breaks things	☐	____ times per ☐ hour ☐ day ☐ week ☐ month
Makes inappropriate sounds	☐	____ times per ☐ hour ☐ day ☐ week ☐ month
Attention Deficits	☐	____ times per ☐ hour ☐ day ☐ week ☐ month
Phobias	☐	____ times per ☐ hour ☐ day ☐ week ☐ month
Overactive for age	☐	____ times per ☐ hour ☐ day ☐ week ☐ month
Separation anxiety	☐	____ times per ☐ hour ☐ day ☐ week ☐ month
Doesn't pay attention	☐	____ times per ☐ hour ☐ day ☐ week ☐ month
Stereotypy (hand-flapping)	☐	____ times per ☐ hour ☐ day ☐ week ☐ month
Arm/Hand biting	☐	____ times per ☐ hour ☐ day ☐ week ☐ month
Thumb sucking	☐	____ times per ☐ hour ☐ day ☐ week ☐ month
Doesn't interact with people	☐	____ times per ☐ hour ☐ day ☐ week ☐ month
Masturbation	☐	____ times per ☐ hour ☐ day ☐ week ☐ month
Pica (eats inedible objects)	☐	____ times per ☐ hour ☐ day ☐ week ☐ month
Insists on routine	☐	____ times per ☐ hour ☐ day ☐ week ☐ month
Other_____	☐	____ times per ☐ hour ☐ day ☐ week ☐ month

What type of supervision does your child require? (Check one)

☐ Can be left unattended for brief periods of time
☐ Needs continuous monitoring, but can be accomplished in a group
☐ Requires 1:1 supervision

OTHER INFORMATION

If your child had an hour to do whatever he/she wanted. Please list which toys, activities, foods, or people he/she would play with:

Toys

1)
2)_____
3)_____
4)_____
5)_____
6)_____
7)_____
8)_____
9)_____

Foods

1)_____
2)_____
3)_____
4)_____
5)_____
6)_____
7)_____
8)_____
9)_____

Activities

1)_____
2)_____
3)_____
4)_____
5)_____
6)_____
7)_____
8)_____
9)_____

People

1)_____
2)_____
3)_____
4)_____
5)_____
6)_____
7)_____
8)_____
9)_____

What are your top 3 goals for your child in the next 6 months, rank the priority of the goal, and describe what specifically needs to be addressed.

Priority:

1= not important, 2= somewhat not important, 3= Neutral, 4= somewhat important, 5= very important

Rank (1-3)	Skill	Priority	Describe
	Communication		
	Play Skills		
	Social Skills		
	Problem Behavior		
	Functional Skills (toileting)		
	Other:_____		

Child Availability

	Monday	Tuesday	Wednesday	Thursday	Friday
8:00 am	☐	☐	☐	☐	☐
9:00 am	☐	☐	☐	☐	☐
10:00 am	☐	☐	☐	☐	☐
11:00 am	☐	☐	☐	☐	☐
12:00 pm	☐	☐	☐	☐	☐
1:00 pm	☐	☐	☐	☐	☐
2:00 pm	☐	☐	☐	☐	☐
3:00 pm	☐	☐	☐	☐	☐
4:00 pm	☐	☐	☐	☐	☐
5:00 pm	☐	☐	☐	☐	☐

Please indicate how interested you are in learning methods to teach your child new skills.

Not at all Interested	Somewhat Interested	Interested	Very Interested	Extremely Interested
☐	☐	☐	☐	☐

Please indicate how many hours each day you and your child are in the same room.

0-2 hours	2 to 4 hours	4 to 6 hours	6 to 8 hours	More than 8 hours
☐	☐	☐	☐	☐

Please indicate how many hours each day you practice new skills with your child.

0-2 hours	2 to 4 hours	4 to 6 hours	6 to 8 hours	More than 8 hours
☐	☐	☐	☐	☐