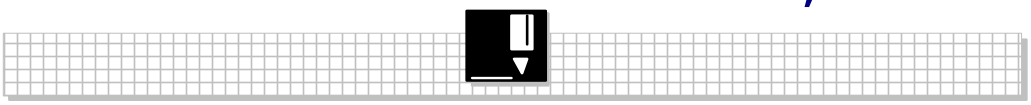
HARDMAN & ASSOCIATES, INC.



"BECAUSE THERE'S MORE TO LEARNING THAN MEETS THE EYE"
5246 Centerville Road * Tallahassee, FL 32309
Phone 850-893-2216 * Fax 850-893-2440 * E-Mail: dri@talstar.com

Salutations,

Enclosed is information concerning the diagnostic test which you requested. Dyslexia Research Institute/Woodland Hall Academy contracts with Hardman & Associates, Inc. to administer this educational battery to determine if dyslexia and/or Attention Deficit Disorders are involved in your child's learning differences. It is administered at Woodland Hall Academy at a pre-arranged appointment.

The test generally takes 4 to 6 hours. This extended period of time allows the tester to observe your child in a variety of situations, over a period of time typical of a school day. You may wait for your child or leave him/her with the test administrator and we will call you 30 minutes before the test is completed.

Generally, we are able to schedule a conference with you within **30 days** of the test. During the conference, we will discuss the results of the test, assist you in understanding the learning patterns of your child, and give you specific information concerning learning programs which match your child's learning needs. Within **four to five weeks**, you will receive a written report which details the same areas we discussed in the conference.

This test battery and conference is unique because it addresses all areas of perception, language, academic performance, and behavioral patterns and develops a learning profile of you which allows you to understand how your child's learning differences are affecting all areas of their life, not just academic areas. Knowing this learning profile allows you to alter the way you, as a parent, may be teaching your child and allows you to judge what learning systems are going to be effective in helping your child learn to his potential.

If you have any questions concerning this testing information, please contact our office.

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TESTING SERVICE

Hardman & Associates conducts a diagnostic test battery to determine if Dyslexia, Attention Deficit Disorders, i.e., Attention Deficit Disorder and/or related disorders, might be the aetiology of the learning and/or behavior problems a person may be having or has had.

The test fee is $725.00. This includes approximately 22 tests conducted on a one-to-one basis. The fee also includes the diagnosis, prognosis, personal one hour conference, and written report. ADDITIONAL CONFERENCES OR FOLLOW-UP CONFERENCES CAN BE ARRANGED AT A FEE OF $75.00 PER HOUR, IF NEEDED. THIS IS NOT A PSYCHOLOGICAL EVALUATION.

Because the test battery is detailed, it requires scheduling of a minimum of 4 to 5 hours to be administered. In addition, scoring, writing, and typing of the report, and conference times must be set up. Therefore, we must ask that a $100.00 non-refundable deposit be paid prior to arranging a testing appointment. The balance of $625.00 is due at the time of testing. Please make all checks for testing payable to HARDMAN & ASSOCIATES, INC.

Due to allergies to many of our staff members, we ask that PERFUMES, COLOGNES, AND OTHER FRAGRANCES NOT BE WORN DURING TESTING OR CONFERENCE.

PLEASE NOTE: It is very important prior to testing that the person taking the battery eat a nutritious meal, eliminating sugar, caffeine, milk and milk products. Please bring a good snack to eat at a break that will be given during the testing. Suggestions for the snack would be: fruit and nuts, peanut butter and crackers, and sugar-free drink or juice.

HARDMAN & ASSOCIATES, INC.

REQUEST FOR SCREENING

Name _____
Last First Middle

Date of Birth_____ Age:_____ Social Security No._____

Current Grade:_____ Current School Year:_____

Home Address:_____
Street Address Apt. #

_____
City State Zip

NAME OF MOTHER:_____
Mother's Phone (Home):_____(Work):_____(Cell)_____
E-Mail Address:_____

NAME OF FATHER:_____
Father's Phone (Home):_____(Work):_____(Cell)_____
E-Mail Address:_____

I request a diagnostic screening to determine whether dyslexia and/or Attention Deficit Disorder, i.e., specific learning disabilities, may be involved.

I understand the test, evaluation, interpretation, and diagnosis will be solely the opinions of the staff of Hardman & Associates, Inc. I understand that the battery of tests, their evaluation, or interpretation is not meant to be used for inclusion or exclusion in any public school program. I understand that all tests are the property of Hardman & Associates, Inc. and the tests themselves will not be available to me.

I understand this is not a psychological evaluation. Hardman & Associates, Inc., will provide me with a personal conference of approximately one hour and with a comprehensive written report on the results of the test battery. Should further conference or additional time be requested of Hardman & Associates, Inc. after the testing and conference, there will be an additional charge of $75.00 per hour. The following people will be attending the conference: _____

_____

I understand that the cost of this evaluation is $725.00. I agree to pay to Hardman & Associates, Inc. a deposit of $100.00, which is NON-REFUNDABLE. The balance of $625.00 is due on or before the test date. In order to set up the diagnostic test, I understand I must complete this Request for Screening and return it with the deposit to secure the testing date.

Signature:_____ Date:_____

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RELEASE OF INFORMATION

Hardman & Associates, Inc. may release information concerning _____'s diagnostic report to the following people:

_____
_____
_____
_____
_____
_____

Who will be attending the conference with you to obtain your test results (i.e., counselor, parents, grandparents, teacher, etc.)? Please list name and relationship.

_____
_____
_____
_____
_____

_____
Authorized Signature

_____
Date

CHILD'S QUESTIONNAIRE

Person(s) completing this form: Father________ Mother__________ Other____________
(Relationship)

IDENTIFYING DATA

Child's Name ____ Sex________

Birth Date ____________________________________ Age ____________________________

Current Grade:___________Current School Year ____________SS No.:_________________

Handedness: Left___ Right___ Child's Health ( ) Good ( ) Poor

- -

Father's Name:____

Father's Address:____
Street Address City State Zip

Father's Phone (Home):_______________(Work):_________________(Cell)_____________

Father's Handedness: Left___ Right___ Father's Health ( ) Good ( ) Poor

- -

Mother's Name:____

Mother's Address:____
Street Address City State Zip

Mother's Phone (Home):______________(Work):_________________(Cell)_____________

Mother's Handedness: Left___ Right___ Mother's Health ( ) Good ( ) Poor

- -

Child lives with ____
(In cases of custody agreements, single-parenthood, or legal guardianship being assumed by person(s) other than a biological parent, Hardman & Associates is required to have documentation of the court-ordered custody agreement with submission of paperwork and deposit. Failure to provide this information will delay your appointment.)

How often does the child visit the non-resident parent?______________________________

Is the child adopted? ( ) Yes ( ) No If adopted, at what age?______________________
If Yes, has this child been told he/she was adopted? ( ) Yes ( ) No

List children, **including applicant**, in order of birth.

Name_____Age_____ Handedness Left ( ) Right ( )

Name_____Age_____ Handedness Left ( ) Right ( )

Name_____Age_____ Handedness Left ( ) Right ( )

Name_____Age_____ Handedness Left ( ) Right ( )

Name_____Age_____ Handedness Left ( ) Right ( )

Do any siblings have any physical or learning disabilities? Yes ( ) No ( )
Specify _____

Present employment of **resident** parents:

Father/Step-Father (Circle)_____Business Phone_____

Mother/Step-Mother (Circle)_____Business Phone_____

Present employment of **non-resident** parents:

Father/Step-Father (Circle)_____Business Phone_____

Mother/Step-Mother (Circle)_____Business Phone_____

Why do you want your child evaluated by the staff of the Hardman & Associates, Inc.?__
_____
_____
_____

What previous evaluations, including neurological, psychological, psychiatric, has the child had? (Please list examining institution or individual, address and diagnosis. Attaching copies of reports is optional)_____
_____
_____

By whom were you referred to the Hardman & Associates, Inc. for testing your child?
_____

When was the first time you felt there was a problem for your child?_____
At that time, what did you think was wrong?_____

_____

At what grade in school did you first detect any problems?_____
_____

What were the first problems noted?_____
_____
_____

What were your child's grades on his/her last report card? Please list academic and conduct areas._____
_____

At what grade in school did a teacher inform you that there were some problems?_____
_____

What did the teacher say was wrong?_____
_____
_____

Have intelligence test scores been erratic or declined over time? yes__ no____

What IQ scores have been reported to you? _____

Are Achievement Test Scores given by educational institutions spotty, i.e., high in some areas, low in others?_____

Has the child been diagnosed as a "poor reader"? yes __ no __

By whom was the diagnosis made?_____

Symptoms, complaints, or characteristics that apply to your child: Put **N** for Now; **P** for in the Past; or **B** for Both

PHYSICAL

General:

_____ recent weight loss	_____ eats well	_____ recent weight gain
_____ coaxed/forced to eat	_____ energetic	_____ overeats
_____ tired	_____ fever	_____ trouble going to sleep
_____ wakes in night	_____ run-down	_____ restless sleep
_____ pale	_____ nightmares	_____ aching in legs or other muscles

Eyes:

_____ tearing
_____ cross-eyes
_____ discharge
_____ light hurts
_____ circles under eyes
_____ itching
_____ pain
_____ blurred vision
_____ burning
_____ doesn't see well
_____ red/inflamed

Nose:

_____ runs
_____ thick discharge
_____ sneezes
_____ sore
_____ picks nose
_____ sniffs
_____ itches
_____ pushes nose up
_____ stuffs up
_____ post-nasal drip
_____ dry

Ears:

_____ stop up
_____ hears poorly
_____ itching
_____ dizziness
_____ have bad odor
_____ drain
_____ frequent infections
_____ noises in ears
_____ hurt
_____ hearing loss
_____ fluid in ears
_____ circles under the eyes

Mouth:

_____ sore gums
_____ grinds teeth
_____ bad teeth
_____ spots on tongue
_____ canker sores
_____ excessive drooling

Throat:

_____ sore
_____ mouth breather
_____ bad breath
_____ swollen glands
_____ clears throat
_____ mucus in throat

Heart & Lungs:

_____ chest hurts
_____ night cough
_____ faints
_____ daily cough
_____ wheezes breathing in or out
_____ hoarse
_____ heart pounds
_____ croup
_____ asthma
_____ short of breath upon exertion
_____ heart races
_____ rattling sounds
_____ spits
_____ short of breath at rest

Stomach & Intestines:

_____ nausea
_____ passes excessive gas
_____ constipation
_____ worms in stools
_____ cramping
_____ vomiting
_____ loose stools
_____ mucus in stools
_____ stomachaches
_____ burning
_____ pain in lower abdomen
_____ blood in stools
_____ soils clothing
_____ bloating
_____ pain in pit of stomach

Kidney, Bladder, & Sex Organs:
As an infant:

_____ diaper rash _____ ammonia odor to urine
_____ urinates too often _____ strains to pass urine

As an older child:

_____ burning or pain _____ frequent urination _____ yeast infections
_____ wets bed _____ wakes in night to urinate

Nerves, Muscles, Bones, and Joints:

_____ headaches _____ dizziness _____ nervous habits
_____ convulsions _____ twitching _____ muscle/joint pains/aches
_____ limp _____ growing pains
_____ changes in walking _____ changes in use of hands or handwriting
_____ clumsiness _____ muscle weakness _____ backaches
_____ shoulder/arm pain _____ leg aches _____ leg cramps
_____ stiffness in joints Other:_____

Skin symptoms:

_____ itchy skin _____ bruises _____ recurring hives
_____ oily skin _____ dry skin _____ pimples
_____ rashes _____ eczema _____ excessive sweating
_____ tingling _____ burning _____ flushing

Nervous symptoms:

_____ headaches _____ fatigue _____ fainting spells
_____ nervousness _____ irritability _____ insomnia
_____ depression _____ behavior problems _____ hyperactivity
_____ inappropriate drowsiness _____ peculiar sensations _____ moodiness
_____ numbness/tingling _____ trouble concentrating
_____ unnatural tiredness Other:_____

ALLERGIES

Has your child ever had eczema or hives? yes__ no____
Has he/she tended to "keep a cold" or stuffy nose? yes__ no____
Has his/her colds generally gone to chest? yes__ no____
Has he/she ever had wheezing or shortness of breath? yes__ no____
Has he/she ever had bouts of bronchitis or croup? yes__ no____
Has any doctor ever made a specific diagnosis
of asthma, hay fever, or allergy? yes__ no____
If answer is yes, please specify:_____

BEHAVIORAL

Activity:

_____ calm	_____ high-strung	_____ erratic/variable
_____ lazy	_____ tendency to get tired	_____ overactive

Perseverance:

_____ tends to give up easily to failure	_____ determined
_____ resistant to discouragement	_____ restructures environment

Self-Image:

_____ sense of self-worth	_____ realizes own strengths/ weaknesses
_____ feels dumb/incompetent	

Peer Group:

_____ shows better judgment in restricted play group
_____ gets along better with younger children
_____ gets along better with same-age children
_____ gets along better with older children
_____ has few close friends
_____ has many casual friends
_____ is overpowering in relation to other children in group
_____ is taken advantage of by other children
_____ displays poor judgment when in a group
_____ becomes over-excitable in play with other children

Frustration Tolerance:

_____ temper tantrums	_____ explosive	_____ upset easily
_____ impulsive	_____ cries easily	_____ pouts easily
_____ lies	_____ cheats	_____ steals
_____ brags	_____ clowns	_____ withdraws
_____ bullies		

<u>Circle</u> your responses to the following:

This child:

* eats (enough, too little, too much)
* (accepts, hates, likes, resists) going to bed
* goes to bed (at a certain time, when he/she wants to), bedtime is _____
* (frequently, occasionally, seldom, never) wets the bed
* seems to feel (good, tired, dizzy, sleepy) in the morning
* (walks, talks, cries, tosses) in sleep

* sleeps with a (toy, plaything, special blanket)
* sleeps (by himself, with parents, with brother, with sister, or someone else)

Nightmares: Describe the child's nightmares, child's reaction, and frequency of occurrence.

_____
_____
_____
_____

This child has had or is still having problems with which of the following:

	What Age(s)	How Often
Bullying	_____	_____
Shyness	_____	_____
Hair twisting	_____	_____
Thumb sucking	_____	_____
Nail biting	_____	_____
Finger sucking	_____	_____
Excessive demands	_____	_____
Fear of darkness	_____	_____
Restlessness	_____	_____
Daydreaming	_____	_____
Truancy	_____	_____
Fighting	_____	_____
Temper tantrums	_____	_____
Resenting discipline	_____	_____
Always hungry	_____	_____
Bad dreams	_____	_____
Other (please describe)	_____	_____

Has this child ever had contact with the police or juvenile authorities? If so, please explain.

_____
_____
_____

Please describe any unusual behavior patterns your child possesses (positive or negative).

_____
_____
_____

This child is (easy, difficult) to manage. Do parents agree?_____

Does the child have a pet?_____ What?_____

What responsibility does child assume for its care?_____
_____

Does he/she have regular chores?_____ Specify:_____
_____

He/she (always, usually, seldom, never) remembers to do those chores.

What activities does the family do together?_____
_____
_____
_____

Describe how this child gets along with:

Father_____
Mother_____
Brothers_____
Sisters_____
Step family members in home_____
_____
Others in home_____
_____

This child will talk more freely with (mother, father, sister, brother, other-give relationship)
_____

This child seems to get most upset when:_____
_____

This child seems happiest when:_____
_____

PREGNANCY, LABOR, BIRTH, AND FIRST WEEK OF LIFE:

Did you have an illness during pregnancy? yes__ no___
If yes, please describe:_____
What medication(s) did the mother take during pregnancy?_____
_____
Did your baby come more than two weeks early? yes__ no___
If yes, how early?_____

Did your baby come more than two weeks late? yes__ no____
If yes, how late?_____
Was labor longer than 24 hours? yes__ no____
Was labor less than 4 hours? yes__ no____
Was the birth Cesarean? yes__ no____
Was labor induced? yes__ no____
If yes, was drug was used to induce labor?_____
Birth weight: _____pounds _____ounces
Was there an RH or AOB incompatibility? yes__ no____
Did your baby have trouble while in hospital? yes__ no____
_____ blue spell _____ yellow jaundice _____ breathing problems
_____ required oxygen _____ infection diagnosed _____ required transfusion
other:_____

FIRST THREE MONTHS OF LIFE:

Did you breast feed your baby? yes__ no____
Did you change his/her formula? yes__ no____
Did your baby cry more than average? yes__ no____
Did your baby suffer from bellyaches or gas? yes__ no____
Did your baby spit up a lot? yes__ no____
Did your baby have any feeding problems? yes__ no____
Did your baby have a stuffy nose? yes__ no____
Did your baby have rattling when breathing? yes__ no____
Did your baby have eczema or skin rashes? yes__ no____
Was mother often blue, depressed, or unusually worried about baby during the first three months of his/her life? yes__ no____
If answer is yes, please specify:_____
_____

THREE MONTHS TO TWELVE MONTHS:

Was he/she a happy baby during this period? yes__ no____
Did you have to take the baby to the doctor for colds or infections more than three times? yes__ no____
Was he/she troubled with (crying, irritability, unhappiness, sleeping problems, or feeding problems) (circle)? yes___ no____
Did he/she have any other unusual problems during the first year of life, or worry you in any other way? yes__ no____
If answer is yes, please specify:_____
_____

Did he/she experience any other health problems
during this age period? yes__ no____
If answer is yes, please specify:_____
_____

TODDLER AND PRE-SCHOOL YEARS (AGES 1 TO 5):

The average infant and young child in this age group experiences many spells of something each year; such as cold, fever, sore throat, or upset stomach.

Did your child have:

More than three or four illnesses in a year?	yes__	no____
Two or more attacks of ear trouble in a year?	yes__	no____
Bronchitis, wheezing, persistent cold, croup?	yes__	no____
In the wintertime, was he/she usually free of colds?	yes__	no____
Did he/she experience any other health problems during this period?	yes__	no____
If answer is yes, please specify:_____		
Did he/she have trouble with locomotion?	yes__	no____
Did he/she have trouble with weaning?	yes__	no____
Did he/she have trouble with toilet training?	yes__	no____
Did he/she wet the bed after three years of age?	yes__	no____
Did he/she understand what was said to him?	yes__	no____
Did he/she have difficulty in discriminating certain sounds?	yes__	no____
Did he/she have a hearing loss?	yes__	no____
Did he/she have difficulty in saying certain words?	yes__	no____
Did he/she stutter?	yes__	no____
Did he/she slur his/her speech?	yes__	no____
Did he/she require speech "correction"?	yes__	no____
Did he/she have many spankings?	yes__	no____
Did he/she hold his/her breath when frustrated?	yes__	no____
Did he/she have temper tantrums?	yes__	no____
Was he/she impulsive?	yes__	no____
Did he/she cry easily when frustrated?	yes__	no____
Did he/she rock or bang his/her head?	yes__	no____
Was he/she a finicky or picky eater?	yes__	no____
Did he/she have vision problems requiring glasses?	yes__	no____
Did he/she get along well with other children?	yes__	no____
Did he/she cling to doll or animal?	yes__	no____
Did he/she talk like a baby?	yes__	no____
Did he/she demand special attention?	yes__	no____
Did he/she call from bed?	yes__	no____

Did he/she dawdle while dressing and eating? yes__ no____
Did he/she try to boss parents and want
his/her way all the time? yes__ no____
Did he/she have to be put to bed? yes__ no____
Did he/she refuse to go to toilet alone? yes__ no____
Any other issues?_____
_____

SIX TO EIGHT YEARS OLD (6 to 8)

Children in this age group continue to experience several spells of minor illnesses a year, such as cold, sore throat, croup, or bronchitis. During this period:

Did he/she have more than three or four illnesses a year yes__ no____
Did he/she have more than three spells of sore
throat or tonsillitis a year? yes__ no____
Did the neck glands often enlarge or become tender? yes__ no____
Did he/she experience any other health problems? yes__ no____
If answer is yes, please specify:_____

Leaving home and starting kindergarten and school is a big step in a child's life.
Did he/she go to kindergarten? yes__ no____
Did he/she like kindergarten, first and second
grades of school? yes__ no____
Did you consider kindergarten, first and second grades
academically adequate? yes__ no____
Did your child have any behavioral problems? yes__ no____
If answer is yes, please specify:_____
Did he/she complain of schoolwork and insist on
being helped with it? yes__ no____
Did he/she refuse to appreciate help although having a
difficult time at school? yes__ no____
Any other issues?_____
_____

NINE TO TWELVE YEARS OLD (9-12)

Children are usually healthier during this age than earlier ages. During this time, did your child:

Go to the doctor for illnesses more than twice a year? yes__ no____
Do well in school? yes__ no____
If answer is no, please specify:_____
Did he/she like school? yes__ no____

If answer is no, please specify:_____
Did he/she have as many friends as he/she, or you, would like? yes__ no____
Did he/she show any behavior problem? yes__ no____
If answer is yes, please specify:_____
Any other issues?_____
_____

School:

_____ shows variability in school performance _____ does poorly in all areas
_____ reads poorly _____ writes poorly
_____ spells poorly _____ lacks musical ability
_____ is slow in finishing work _____ does poorly in math
_____ lacks interest in school _____ dislikes school

Remedial Help:

_____ has been retained: grade _____ _____ changed schools
_____ should have been retained but wasn't _____received remedial help in school
_____ received tutorial help outside of school
_____ psychiatric or psychological counseling

GENERAL ILLNESSES, INFECTION, OPERATIONS, OR OTHER PROBLEMS:

Has your child had a serious head injury? yes__ no____
Has he/she ever had a kidney or bladder infection? yes__ no____
Has he/she ever had any trouble with his/her feet and legs? yes__ no____
Has he/she ever had a convulsion? yes__ no____
Any other issues?_____
_____

Circle any of the following conditions your child has had:
German measles (rubella), red measles, mumps, chicken pox, roseola, whooping cough, trench mouth, loss of consciousness, serious accidents, broken bones, pneumonia, drug reactions, removal on tonsils and adenoids, other surgical operations, diseases or health problems. Specify:_____
_____

Describe any serious accidents this child has had:

Accident	Age (at time of accident)	Treatment

This child was last seen by Doctor_____ on (Date)_____
The physical examination revealed_____
_____

Is this child **currently** taking any medication(s)? yes__ no___
Medication 1:_____
Dosage?_____ Prescribed by?_____ How long?_____
Medication 2:_____
Dosage?_____ Prescribed by?_____ How long?_____
Medication 3:_____
Dosage?_____ Prescribed by?_____ How long?_____

Has this child taken any other medication(s) in the **past twelve months** that he/she is not taking now? yes__ no___
Medication 1:_____
Dosage?_____ Prescribed by?_____ How long?_____
Medication 2:_____
Dosage?_____ Prescribed by?_____ How long?_____

Has this child's hearing been checked? yes__ no___
If so, by whom?_____ Date:_____ Results:_____
_____

Has this child's vision been checked? yes__ no___
If so, by whom?_____ Date:_____ Results:_____
_____

Is this child on a special diet? yes__ no___
Describe:_____

DEVELOPMENT AND GENERAL MANAGEMENT:

Do you feel that you have more than the usual problems in managing your child? yes__ no___
Have you thought of him/her as being a nervous child? yes__ no___
Have you thought of him/her as a slow learner? yes__ no___
When did he/she:
Roll over?_____ Sit alone?_____ Stand alone?_____
Walk across the room alone?_____
When could he/she say twenty words you could understand?_____
Is there any disagreement between the mother and father as to how the child should be handled? yes__ no___

HOME ENVIRONMENT

House:

_____ old	_____ new	_____ damp
_____ dusty	_____ moldy	_____ crowded
_____ near factory	_____ near barn	_____ near poultry yard
_____ lots of weeds	_____ central heating	_____ gas or oil heat
_____ electric heat	_____ many rugs & rug pads	
_____ pet in home	_____ cigarette smoke	
_____ near gas-pumping station	_____ carpet	

Bedroom:

_____ feather pillow	_____ foam rubber pillow
_____ cotton mattress	_____ dustproof mattress cover
_____ stuffed animals in room	_____ rugs
_____ curtains	_____ furnace outlet in room
_____ sleeps alone	_____ shares room
_____ shares bed	_____ pet in room

Chemical Fumes or odors in the home:

_____ gas stove in kitchen	_____ insecticides
_____ sprays	_____ pine paneling
_____ plastic odors	

<u>FOOD INTAKE</u> - (PLEASE CHECK WHICH ARE TAKEN IN REGULARLY BY YOUR CHILD)

Beverages:

_____ cow's milk	_____ coffee	_____ tea
_____ orange juice	_____ apple juice	_____ tomato juice
_____ chocolate milk	_____ Coke/Pepsi	_____ 7-UP/Sprite, etc
_____ sports drinks	_____ energy drinks	_____ water

_____ other:_____

Meats:

_____beef	_____ pork	_____ chicken
_____ turkey	_____ lamb	_____ fish
_____ shrimp	_____ lobster	_____ eggs
_____ vegetarian	other:_____	

Fruits:

_____ orange	_____ apple	_____ banana
_____ grapes	_____ peaches	_____ pineapple

_____ strawberries
_____ other:_____

Vegetables:

_____ peas	_____ beans	_____ Irish potato
_____ sweet potato	_____ corn	_____ tomato
_____ lettuce	_____ carrots	_____ other:_____

Breads/Cereals:

_____ wheat bread	_____ corn bread	_____ crackers	_____ cookies
_____ spaghetti	_____ macaroni	_____ noodles	_____ white bread
_____ cereals (cooked & dry)	_____ other:_____		

Miscellaneous:

_____ pickles	_____ olives	_____ spices
_____ potato chips	_____peanuts	_____ peanut butter
_____ popcorn	_____ butter	_____margarine
_____ sugar	_____ pizza	_____ catsup
_____ chocolate candy	_____ gummies	

___ other:_____

Please list what you would consider your child's favorite food and snack food: _____
_____
_____

RECREATION AND INTERESTS

Circle **ALL** that apply.

This child has (many, average, few, no) friends.

Approximately how much television does this child watch per day?_____

Approximately how much screen time (tablet, computer games, X-Box, Gameboy, video games, etc.) does this child play on per day?_____

In recreational activities, this child most often prefers the company of others (younger, older, his/her own age).

If he/she could, they would like to have (many, few) friends; do things (alone, with just one friend, in a group).

This child likes best to associate with (boys, girls, both the same).

This child seems to enjoy most those games that are (rough, noisy, quiet; require a great deal of make-believe; require little physical activity; have definite rules).

This child, when losing a game, usually (loses his/her temper, keeps right on playing, works even harder, seems to "give up", blames someone or something for the loss, gets discouraged and wants to quit).

This child likes best to socialize (at home, at someone else's house).

This child likes best to ("make rules" and decide how things will go, have someone else make the decisions).

This child (likes, dislikes) close attention or supervision.

What does he/she like to do for recreation?_____
_____
_____

This child takes part in which of the following activities outside of home or school:
Scouts_____ YMCA_____ Clubs_____ Youth Groups_____
Other_____

Please describe any unusual behavior (positive or negative) you have observed at these activities:_____
_____

What plans do you have for changes in such areas as family, school, social, medical, etc., that have not been mentioned elsewhere in this questionnaire?_____
_____

Is there anything else you think we should be aware of?_____
_____
_____
_____
_____
_____

FAMILY HISTORY: PUT **P** FOR PARENTS, **G** FOR GRANDPARENTS, **OF** FOR OTHER FAMILY MEMBERS, OR **S** FOR SIBLINGS IF THEY HAVE A HISTORY OF:

(Please list in following blank the symbol for applicable member of family)

_____ diabetes	_____ low blood sugar	_____ convulsions
_____ tuberculosis	_____ asthma	_____ hay fever
_____ migraines	_____ "nervous breakdown"	_____ retardation
_____ learning disability	_____ alcoholism	_____ allergies

Have members of either family had difficulty in school? yes___ no____
If answer is yes, please specify who:_____

Last grade in school finished by father:_____
Last grade in school finished by mother:_____

Does father plan additional education? yes___ no____
Does mother plan additional education? yes___ no____

Occupation of father:_____
Occupation of step-father:_____
Occupation of mother:_____
Occupation of step-mother:_____

Is there a satisfactory relationship between the parents? yes___ no____

Are the parents of this child living together? yes___ no____

Are there significant family or marital problems? yes___ no____

Are the parents of this child divorced? yes___ no____

Do the adults in the home usually agree on the rearing of the child? yes___ no____

Many families experience trouble making ends meet. Is your family's income enough for satisfactory rearing of the child? yes___ no____