Prenatal and Neurodevelopmental Assessment

These questions will help us better understand any developmental, learning, or behavioral challenges your child may have. Please check the box that best describes your child's challenges. For supplemental questions use the blank link after answering yes to clarify your response.

	Symptoms	Never	Sometimes	Often
1.	Forgets to do what he or she was just asked to do	0	1	2
2.	Often loses things	0	1	2
3.	Difficulty following simple directions	0	1	2
4.	Difficulty transitioning from activity to activity	0	1	2
5.	Difficulty remembering recently learned information or skills	0	1	2
6.	Difficulty following multiple step or verbal instructions	0	1	2
7.	Makes the same mistakes over and over	0	1	2
8.	Difficulty understanding left from right, up from down	0	1	2
9.	Clumsy, always bumping into things	0	1	2
10.	Writes letters and words not clearly or backwards	0	1	2
11.	Difficulty copying a simple shape or pattern	0	1	2
12.	Difficulty learning or repeated a grade	0	1	2
13.	Has temper tantrums and outbursts that seem to come out of nowhere	0	1	2
14.	Can't sit still, always on the go	0	1	2
15.	Difficulty falling asleep or wakes frequently at night	0	1	2
16.	Sensitive to sounds, light or touch	0	1	2
17.	Difficulty paying attention	0	1	2
18.	Doesn't think before doing	0	1	2
19.	Difficulty waiting his or her turn	0	1	2
20.	Hits other children or adults, gets into fights, or yells at adults	0	1	2
21.	Touches other children or adults inappropriately	0	1	2
22.	Takes other's property (toys, food, clothes, money)	0	1	2
23.	Has or previously had delay in the development of speech	0	1	2
24.	Difficulty following conversation or reading social cues	0	1	2
25.	Acts younger than his or her age	0	1	2
26.	Overly friendly to strangers	0	1	2
27.	Difficulty fitting in with kids in her or his age group, prefers to play with younger children	0	1	2
28.	Gullible and easily talked into doing actions they might not otherwise do	0	1	2
29.	Difficulty understanding consequences of actions	0	1	2
30.	Needs constant reminding to complete daily living skills such as dressing, eating, showering, brushing teeth, using the toilet or managing daily schedule	0	1	2
31.	Current or past delay in walking, running, climbing	0	1	2
32.	Difficulty making eye contact when speaking or listening to others	0	1	2
33.	Difficulties with behavior before age 5	0	1	2

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Supplemental Questions

- ☐ Does anyone in your immediate family (parents, grandparents, siblings or your child) have a history of developmental or behavioral challenges (autism, intellectual disability, or psychiatric illness)?
  - Yes _____
  - No
- ☐ How far along were you (or your child's mother) when you discovered you were pregnant?
  - Less than 8 weeks
  - 8-12 weeks
  - 12-24 weeks
  - 24-40 weeks
- ☐ Were there any medical issues during your (or your child's mother's) pregnancy?
  - Yes _____
  - No
- ☐ Were you (or your child's mother) prescribed medication during your pregnancy?
  - Yes _____
  - No
- ☐ How much alcohol did you (or your child's mother) drink *before* you found out you were pregnant (beer, wine, liquor)?
  - none
  - 1-2 drinks a week
  - 3-4 drinks a week
  - 4-7 drinks a week
  - 1-2 drinks a day
  - 2-3 drinks a day
  - 4 or more drinks a day
- ☐ How much alcohol did you (or your child's mother) drink *after* you discovered your pregnancy?
  - none
  - 1-2 drinks a week
  - 3-4 drinks a week
  - 4-7 drinks a week
  - 1-2 drinks a day
  - 2-3 drinks a day
  - 4 or more drinks a day

- ☐ Did you (or your child's mother) use any other drugs such as marijuana, cocaine, or opiates during your pregnancy?
  - Yes _____
  - No
- ☐ Was your child born with a low birth weight or have problems gaining weight or growing?
  - Yes _____
  - No

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- ☐ Is your child adopted or in foster care?
  - Yes
  - No
- ☐ Were you ever a victim of domestic violence?
  - Yes
  - No
- ☐ Did your child ever have an elevated lead level?
  - Yes _____
  - No
- ☐ Did you have a stressful pregnancy because of events going on in your life at the time?
  - Yes
  - No

Score

Neurocognitive (questions 1-12)	Self-Regulation (questions 13-22)	Adaptive (questions 23-33)
Cut off=12 or more	Cut off=10 or more	Cut off=11 or more

Child's Name: _____

Date of Birth: _____

Date of Evaluation: _____