Children's MINNESOTA

Our Community Clinics
Children's: Hugo, West St. Paul
Partners in Pediatrics: Brooklyn Park, Maple Grove, Plymouth, Rogers, St. Louis Park

SCHOOL PROBLEMS EVALUATION
MEDICAL HISTORY FORM

Child's name: _____

Birthdate: _____ Date form filled out: _____

Your name: _____ Relationship to child: _____

Primary Phone: _____ Secondary Phone: _____

Name of School: _____ Grade: _____

Referred by: _____

Please list the problems with which you want help for your child:

1. _____
2. _____
3. _____

When did these problems begin? _____

What do you hope to get out of this evaluation? _____

_____

_____

Please list any previous evaluations or treatment for the current problems and attach copies if available:

Date Name of Physician, psychologist, agency, or clinic

_____

_____

SCHOOL

Please describe your child's current classroom placement and services (attach an Individual Educational Plan [IEP] and copies of any school psycho-educational reports if available):

Special Services Time/days per week

_____

_____

_____

Please indicate current classroom interventions:

- ❒ Behavior chart
- ❒ Seating preference
- ❒ Time to think or behavior room
- ❒ Social skills group
- ❒ Other _____

Name: _____ Date of Birth: _____

School performance: What has the school told you about your child's:

Behavior? _____

_____

Work completion? _____

_____

Academic progress? _____

_____

Does your child often bring home work that should have been done during class time? ❒ Yes ❒ No

Handwriting/ neatness: _____

_____

Please describe previous day care, preschool or school problems:

Grade/year School/Center name Problems

_____

_____

_____

_____

_____

HOME/FAMILY

Family Member	Name	Years of School/Degree	Occupation
Parent 1			
Parent 2			
Step Parent 1			
Step Parent 2			

Parents are: ❒ married ❒ separated ❒ divorced ❒ never married

Custody arrangements if applicable: _____

Who lives at home with this child? _____

Please share any history of significant family stressors (e.g. marital, financial, medical, work-related): _____

_____

_____

Briefly describe any behavior or family issues that bother you in regard to this child:

_____

_____

_____

_____

_____

Please describe any conflict surrounding homework: _____

_____

_____

_____

Name: _____ Date of Birth: _____

Please describe behavior management strategies that have been used at home, and how effective are they:

_____

_____

_____

SOCIAL

Describe any problems your child may have in making and keeping friends: _____

_____

_____

Please describe any aspect of your child's social life that bothers you: _____

_____

_____

List the organized or leisure time activities your child participates in (e.g.., sports, scouts, religious, free time play):

_____

_____

SELF-ESTEEM

How do you feel these problems are affecting your child's self-esteem? _____

_____

_____

BEHAVIOR HISTORY:

If your child has experienced any of these behavior problems, please record the ages they occurred.

BEHAVIOR	NO	YES	AGES
Colic			
Infant feeding problems			
Difficulty falling asleep			
Difficulty staying asleep			
Excessive crying			
Tantrums			
Difficulty being consoled			
Overactivity or hyperactivity			
Difficulty keeping to a schedule			
Difficulty being satisfied or easily bored			
Thumb sucking			
Impulsiveness			
Anxiety, fears, phobias, excessive worry			
Obsessive or compulsive behaviors			

Name: _____ Date of Birth: _____

CHILD'S HEART HISTORY:

If your child has experienced any of these medical problems, please record the ages they occurred:

PROBLEM	NO	YES	IF YES, PLEASE EXPLAIN
Fainting or dizziness during or after exercise			
Extreme shortness of breath during exercise (without asthma)			
Extreme fatigue with exercise (different from peers)			
Palpitations, increased heart rate, extra or skipped beats			
Rheumatic Fever			
An unexplained seizure			
Heart murmur			
An unexplained, noticeable change in exercise tolerance			
High Blood Pressure			
Previously detected Cardiac Disease			

REVIEW OF SYSTEMS:

If your child has experienced any of these medical problems, please record the ages they occurred:

MEDICAL PROBLEM	NO	YES	AGES
Food reactions			
Appetite problems			
Underweight or overweight			
Difficulty sleeping			
Skin rashes – chronic or frequent			
Hair loss			
Unusual moles or birthmarks			
Recurrent or frequent ear infections			
Hearing loss			
Visual problems or wears glasses			
Recurrent tonsillitis			
Sinus infections			
Asthma, wheezing, exercise intolerance			
Bronchitis			
Pneumonia			
Stomachaches			
Diarrhea			
Constipation			
Soiled underwear			
Recurrent vomiting			
Bloody stools			
Daytime wetting			
Bedwetting			
Menstrual periods Problems			
Age menstruation started _____			
Joint pain or backache			
Scoliosis			
Diabetes			
Seizures or convulsions			
Headaches			
Tics, twitches, or involuntary movements or noises			
Serious head injury or knocked out			
Other (specify)			

Name: _____ Date of Birth: _____

BIOLOGICAL FAMILY HISTORY

These problems sometimes run in families. We are interested if anyone in your family other than your child may have any of these. Place an X in the appropriate column for each affected family member. If more than one brother or sister has one of these problems, put an X for each one in the appropriate column.

BIOLOGICAL FAMILY HISTORY	Child's mother	Child's father	Child's brother(s)	Child's sister(s)	Others (Specify)
LEARNING					
Difficulty with reading					
Difficulty with arithmetic/math					
Difficulty with writing/spelling					
Speech problems					
Held back in school					
Honor student					
Intellectual Disability (Low IQ)					
BEHAVIOR					
Hyperactivity/ADD/ADHD					
Behavior problems before age 12					
Behavior problems as a teenager					
Trouble with law					
Dropped out of high school					
MENTAL HEALTH					
Depression/manic depression/bipolar					
Obsessive compulsive disorder					
Anxiety disorder					
Suicide attempted/committed					
Psychiatric hospitalization					
Participated in psychotherapy					
Drug or alcohol abuse					
MEDICAL/NEUROLOGICAL					
Seizures or convulsions					
Tics, twitches, or Tourette's syndrome					
Thyroid problems					
High blood pressure					
High cholesterol					
Kidney disease					
Asthma/allergies					
Cancer					
Other					

BIOLOGICAL FAMILY HEART HISTORY	NO	YES	RELATIONSHIP TO CHILD
Sudden, unexpected, unexplained death before age 50			
Died suddenly of "heart problems" before age 50			
Unexpected fainting or seizures			
Enlarged Heart: Hypertrophic Cardiomyopathy			
Dilated Cardiomyopathy			
Heart Rhythm problems: Long QT Syndrome			
Short QT Syndrome			
Brugada Syndrome			
Catecholaminergic Ventricular Tachycardia			
Arrhythmogenic Right Ventricular Cardiomyopathy			
Wolff-Parkinson-White Syndrome			
Cardiac Arrhythmias (irregular heart beat)			
Marfan Syndrome			
Heart attack occurring before age 35			
Pacemaker or implanted defibrillator			
Event requiring resuscitation in family member less than 35 years old			

Children's MINNESOTA

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Partners in Pediatrics: Brooklyn Park, Maple Grove, Plymouth, Rogers, St. Louis Park

SCHOOL (WORK) EVALUATION INITIAL SELF REPORT

Name: _____ Date of Birth: _____

Today's Date: _____ Your Phone Number: _____

- Please summarize your main concerns: _____
  _____
- When did these difficulties begin? _____
- How has this affected your schoolwork and/or job? _____
  _____
- How has this affected your relationship with your family? _____
  _____
- How has this affected your relationship with your friends, classmates, team members, or coworkers?
  _____
  _____
- Have you been on medication for ADHD, Depression, Anxiety, or Mental Health in the past? ❒ Yes ❒ No
  If yes, when and how treated? _____

Directions: When completing this form, please think about your behaviors in the past 6 months.

SYMPTOMS	NEVER	OCCASIONALLY	OFTEN	VERY OFTEN
1. I do not pay attention to details or make careless mistakes with, for example, homework or other work.	0	1	2	3
2. I have difficulty keeping attention to what needs to be done.	0	1	2	3
3. I do not seem to listen well when spoken to directly.	0	1	2	3
4. I do not follow through when given directions and fail to finish activities.	0	1	2	3
5. I have difficulty organizing tasks and activities.	0	1	2	3
6. I avoid, dislike, or do not want to start tasks that require ongoing mental effort.	0	1	2	3
7. I lose things necessary for tasks or activities (keys, glasses, wallet, important papers or assignments).	0	1	2	3
8. I am easily distracted by noises or other stimuli.	0	1	2	3
9. I am forgetful in daily activities.	0	1	2	3
10. I fidget and squirm a lot.	0	1	2	3
11. I have trouble remaining seated when it is expected.	0	1	2	3
12. I am restless and agitated	0	1	2	3
13. I have trouble engaging in leisurely activities quietly.	0	1	2	3
14. I am "on the go" and have a hard time relaxing.	0	1	2	3
15. I talk too much.	0	1	2	3
16. I blurt out answers before questions have been completed.	0	1	2	3
17. I have difficulty waiting my turn in conversations, activities or driving.	0	1	2	3
18. I interrupt or intrude in on others' conversations and/or activities.	0	1	2	3

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD

Continued on Reverse

Name: _____ Date of Birth: _____

SYMPTOMS	NEVER	OCCASIONALLY	OFTEN	VERY OFTEN
19. I argue with others often.	0	1	2	3
20. I lose my temper easily.	0	1	2	3
21. I actively defy or refuse to go along with others' requests and/or activities.	0	1	2	3
22. I blame others for my mistakes or misbehavior.	0	1	2	3
23. I am touchy or easily annoyed by others.	0	1	2	3
24. I am angry or resentful.	0	1	2	3
25. I am spiteful and want to get even.	0	1	2	3
26. I have bullied, threatened, or intimidated others.	0	1	2	3
27. I start physical fights.	0	1	2	3
28. I lie to get out of trouble or to avoid obligations.	0	1	2	3
29. I am physically cruel to people.	0	1	2	3
30. I have stolen things that have value.	0	1	2	3
31. I have deliberately destroyed others' property.	0	1	2	3
32. I have used a weapon that can cause serious harm (bat, knife, brick, gun).	0	1	2	3
33. I have been physically cruel to animals.	0	1	2	3
34. I have deliberately set fires to cause damage.	0	1	2	3
35. I have broken into someone else's home, business, or car.	0	1	2	3
36. I have stayed out at night without informing others of my whereabouts.	0	1	2	3
37. I have left home overnight without warning.	0	1	2	3
38. I have forced someone into sexual activity.	0	1	2	3
39. I am fearful, anxious, or worried.	0	1	2	3
40. I am afraid to try new things for fear of making mistakes.	0	1	2	3
41. I feel worthless or inferior.	0	1	2	3
42. I blame myself for problems, feel guilty.	0	1	2	3
43. I feel lonely, unwanted, or unloved; complain that "no one loves me".	0	1	2	3
44. I am sad, unhappy, or depressed.	0	1	2	3
45. I am self-conscious or easily embarrassed.	0	1	2	3

PERFORMANCE	EXCELLENT	ABOVE AVERAGE	AVERAGE	SOMEWHAT OF A PROBLEM	PROBLEMATIC
46. Overall school/work performance	1	2	3	4	5
47. Reading	1	2	3	4	5
48. Math	1	2	3	4	5
49. Writing	1	2	3	4	5
50. Relationships with parents.	1	2	3	4	5
51. Relationships with siblings.	1	2	3	4	5
52. Relationships with peers.	1	2	3	4	5
53. Relationship with spouse/significant other	1	2	3	4	5

COMMENTS:

Provider Initials:_____

PHQ-9 modified for Adolescents (PHQ-A)

Name: _____ **Clinician:** _____ **Date:** _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an **"X"** in the box beneath the answer that best describes how you have been feeling.

	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

☐Yes ☐No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

☐Not difficult at all ☐Somewhat difficult ☐Very difficult ☐Extremely difficult

Has there been a time in the **past month** when you have had serious thoughts about ending your life?

☐Yes ☐No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

☐Yes ☐No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Office use only: **Severity score:** _____

Modified with permission from the PHQ (Spitzer, Williams & Kroenke, 1999) by J. Johnson (Johnson, 2002)

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(*For office coding: Total Score T*____ = ____ + ____ + ____)

_____ Provider initials

Children's MINNESOTA

Our Community Clinics
Children's: Hugo, West St. Paul
Partners in Pediatrics: Brooklyn Park, Maple Grove, Plymouth, Rogers, St. Louis Park

PARENT SCHOOL PROGRESS INITIAL EVALUATION

Child's Name: _____ Date of Birth: _____ Today's Date: _____

Parent's Name: _____ Parent's Phone Number: _____

Directions: **Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.**

SYMPTOMS	NEVER	OCCASIONALLY	OFTEN	VERY OFTEN
1. Does not pay attention to details or makes careless mistakes with, for example, homework.	0	1	2	3
2. Has difficulty keeping attention to what needs to be done.	0	1	2	3
3. Does not seem to listen when spoken to directly.	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand).	0	1	2	3
5. Has difficulty organizing tasks and activities.	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort.	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books).	0	1	2	3
8. Is easily distracted by noises or other stimuli.	0	1	2	3
9. Is forgetful in daily activities.	0	1	2	3
10. Fidgets with hands or feet or squirms in seat.	0	1	2	3
11. Leaves seat when remaining seated is expected.	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected.	0	1	2	3
13. Has difficulty playing or beginning quiet play activities.	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor".	0	1	2	3
15. Talks too much.	0	1	2	3
16. Blurts out answers before questions have been completed.	0	1	2	3
17. Has difficulty waiting his or her turn.	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities.	0	1	2	3
19. Argues with adults.	0	1	2	3
20. Loses temper.	0	1	2	3
21. Actively defies or refuses to go along with adults' requests and/or activities.	0	1	2	3
22. Deliberately annoys people.	0	1	2	3
23. Blames others for his or her mistakes or misbehavior.	0	1	2	3
24. Is touchy or easily annoyed by others.	0	1	2	3
25. Is angry or resentful.	0	1	2	3
26. Is spiteful and wants to get even.	0	1	2	3
27. Bullies, threatens, or intimidates others.	0	1	2	3
28. Starts physical fights.	0	1	2	3
29. Lies to get out of trouble or to avoid obligations (i.e. "cons" others).	0	1	2	3
30. Is truant from school (skips school) without permission.	0	1	2	3
31. Is physically cruel to people.	0	1	2	3
32. Has stolen things that have value.	0	1	2	3
33. Deliberately destroys others' property.	0	1	2	3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun).	0	1	2	3
35. Is physically cruel to animals.	0	1	2	3
36. Has deliberately set fires to cause damage.	0	1	2	3
37. Has broken into someone else's home, business, or car.	0	1	2	3
38. Has stayed out at night without permission.	0	1	2	3
39. Has run away from home overnight.	0	1	2	3
40. Has forced someone into sexual activity.	0	1	2	3

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD

Continued on Reverse

Name: _____ Date of Birth: _____

SYMPTOMS	NEVER	OCCASIONALLY	OFTEN	VERY OFTEN
41. Is fearful, anxious, or worried.	0	1	2	3
42. Is afraid to try new things for fear of making mistakes.	0	1	2	3
43. Feels worthless or inferior.	0	1	2	3
44. Blames self for problems, feels guilty.	0	1	2	3
45. Feels lonely, unwanted, or unloved; complains that “no one loves him or her”.	0	1	2	3
46. Is sad, unhappy, or depressed.	0	1	2	3
47. Is self-conscious or easily embarrassed.	0	1	2	3

PERFORMANCE	EXCELLENT	ABOVE AVERAGE	AVERAGE	SOMEWHAT OF A PROBLEM	PROBLEMATIC
48. Overall school performance	1	2	3	4	5
49. Reading	1	2	3	4	5
50. Writing	1	2	3	4	5
51. Mathematics	1	2	3	4	5
52. Relationships with parents.	1	2	3	4	5
53. Relationships with siblings.	1	2	3	4	5
54. Relationships with peers.	1	2	3	4	5
55. Participation in organized activities (e.g. teams)	1	2	3	4	5

COMMENTS:

Provider Initials:_____

Children's MINNESOTA

AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION

30342 (12/18)

MRN: _____(*office use only*)

Children's Minnesota
Health Information Management (HIM)
5901 Lincoln Drive
Mail stop CBC-2-HIM
Edina, MN 55436
Phone: 952-992-5200
Release of Information Fax: 612-813-5980

(O*ffice use only*)
Staff Initials _____

# of pages _____

ID Verified: ☐ Yes
Comments:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

How to upload to MyChildren's portal

1. Print and complete this form.
2. Scan or take a photo of your completed form.
3. Log in to your MyChildren's account.
4. Create a new message in MyChildren's. Attach this completed form and send to **Health Information Management.**

*Option available if you have been seen at the Minneapolis or St. Paul hospital or clinic locations.

Patient Name _____ Date of Birth _____

I authorize (release from):

_____
Hospital/Clinic/School/Other

_____ _____
Address/City/State/Zip Phone/Fax

To release To: _____
Name/Hospital/Clinic/School/Other

_____ _____
Address/City/State/Zip Phone/Fax

Purpose of release: ☐Continuation of Care ☐Insurance Claim ☐Litigation ☐Personal ☐School ☐Other: _____

*Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 C.F.R. §164.524

Information needed by (date): _____

Please check or specify requested information below. Information is routinely copied for the previous two years. ☐ Dates of Service: _____

Information needed from the following clinics:
☐Children's Heart Clinic ☐Children's Hospitals and Clinics ☐ Children's Hugo Clinic
☐Partners in Pediatrics (PIP) Clinic ☐Children's West St. Paul Clinic

☐Discharge Summary
☐Emergency Department Visit
☐History and Physical
☐Progress Notes
☐Billing Information
☐Operative Report
☐Laboratory Report
☐X-Ray Report
☐Consultation
☐Testing Records
☐X-Ray Image(s)
☐Immunizations
☐Mental Health Record
☐Clinic Visit
☐Other:_____

☐ School nurse Electronic Medical Record access **(Includes All Health Information)**
☐**All Health Information (Does not include imaging or billing information)**

Release Method requested: ☐ Paper ☐ Fax (patient care only) ☐ Verbal ☐ MyChildren's

☐ Email_____(HIM only)

- I understand that my health record may include information relating to mental or behavioral health, chemical dependency, child abuse, sickle cell anemia, genetic conditions, acquired immunodeficiency syndrome (AIDS), and/or human immunodeficiency virus (HIV). If I don't want these to be released, I will place a check mark here: _____.
  I don't want the following records released: _____.
- I understand that I have a right to revoke this authorization at any time. I understand that if I stop this authorization, I must do so in writing to Health Information Management. I understand that stopping this authorization will not apply to information that has already been released or disclosed.
- I understand that authorizing the release of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by federal privacy rules.
- **This authorization will end one year from the date the form is signed unless I indicate an earlier date or event here:** _____

_____ _____
Signature of the Parent/Guardian/Patient Date Signed

Relationship to Patient: ☐Mother ☐Father ☐Patient ☐Other: _____

* R O I *

Children's MINNESOTA

AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION

30342 (12/18)

MRN: _____(*office use only*)

Children's Minnesota
Health Information Management (HIM)
5901 Lincoln Drive
Mail stop CBC-2-HIM
Edina, MN 55436
Phone: 952-992-5200
Release of Information Fax: 612-813-5980

(O*ffice use only*)
Staff Initials _____

# of pages _____

ID Verified: ☐ Yes
Comments:

_____
_____
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*Option available if you have been seen at the Minneapolis or St. Paul hospital or clinic locations.

Patient Name _____ Date of Birth _____

I authorize (release from):

_____
Hospital/Clinic/School/Other

_____ _____
Address/City/State/Zip Phone/Fax

To release To: _____
Name/Hospital/Clinic/School/Other

_____ _____
Address/City/State/Zip Phone/Fax

Purpose of release: ☐Continuation of Care ☐Insurance Claim ☐Litigation ☐Personal ☐School ☐Other: _____

*Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 C.F.R. §164.524

Information needed by (date): _____

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Information needed from the following clinics:
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☐Partners in Pediatrics (PIP) Clinic ☐Children's West St. Paul Clinic

☐Discharge Summary
☐Emergency Department Visit
☐History and Physical
☐Progress Notes
☐Billing Information
☐Operative Report
☐Laboratory Report
☐X-Ray Report
☐Consultation
☐Testing Records
☐X-Ray Image(s)
☐Immunizations
☐Mental Health Record
☐Clinic Visit
☐Other:_____

☐ School nurse Electronic Medical Record access **(Includes All Health Information)**
☐**All Health Information (Does not include imaging or billing information)**

Release Method requested: ☐ Paper ☐ Fax (patient care only) ☐ Verbal ☐ MyChildren's

☐ Email_____(HIM only)

- I understand that my health record may include information relating to mental or behavioral health, chemical dependency, child abuse, sickle cell anemia, genetic conditions, acquired immunodeficiency syndrome (AIDS), and/or human immunodeficiency virus (HIV). If I don't want these to be released, I will place a check mark here: _____.
  I don't want the following records released: _____.
- I understand that I have a right to revoke this authorization at any time. I understand that if I stop this authorization, I must do so in writing to Health Information Management. I understand that stopping this authorization will not apply to information that has already been released or disclosed.
- I understand that authorizing the release of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by federal privacy rules.
- **This authorization will end one year from the date the form is signed unless I indicate an earlier date or event here:** _____

_____ _____
Signature of the Parent/Guardian/Patient Date Signed

Relationship to Patient: ☐Mother ☐Father ☐Patient ☐Other: _____

* R O I *

Children's MINNESOTA

Our Community Clinics
Children's: Hugo, West St. Paul
Partners in Pediatrics: Brooklyn Park, Calhoun, Maple Grove, Plymouth, Rogers

MIDDLE/HIGH SCHOOL PROGRESS REPORT

Student Name: _____ Date of Birth: _____ Today's Date: _____

Teacher: _____ Class/Subject: _____ Period or Time: _____

Please rate this student based on current school performance to this point in the term.
(Circle appropriate answers for each row)

1. Approximate current Grade	A	B	C	D	F or IC
2. % of assigned work completed	90-100%	80-89%	66-79%	50-65%	0-49%
3. Able to pay attention without prompting	Always	Often	Sometimes	Rarely	Never
4. Follows class discussion and teacher instructions	Always	Often	Sometimes	Rarely	Never
5. Learns new material	Very Quickly	Quickly	Average	Slowly	Very Slowly
6. Follows rules of behavior	Always	Often	Sometimes	Rarely	Never

Comments: