

## SCHOOL PROBLEMS EVALUATION MEDICAL HISTORY FORM

Child's name: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Date form filled out: \_\_\_\_\_

Your name: \_\_\_\_\_ Primary Phone: \_\_\_\_\_

Relationship to child: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of School: \_\_\_\_\_ Grade: \_\_\_\_\_

Referred by: \_\_\_\_\_

Child's private physician: \_\_\_\_\_

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

<u>Date</u>	<u>Name of Physician, psychologist, agency, or clinic</u>
_____	_____
_____	_____
_____	_____

Please attach a recent picture:



Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

When did these problems begin? \_\_\_\_\_

What do you hope to get out of this evaluation? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**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):

<u>Special Services</u>	<u>Time/days per week</u>
_____	_____
_____	_____
_____	_____

Please indicate current classroom interventions:

- Behavior chart
- Seating preference
- Time to think or behavior room
- Social skills group
- Other \_\_\_\_\_

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:

<u>Grade/year</u>	<u>School/Center name</u>	<u>Problems</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**HOME/FAMILY**

Family Member	Name	Years of School/Degree	Occupation
Father			
Mother			
Stepfather			
Stepmother			

Parents are:  married  separated  divorced  never married

Please share any history of significant (if any) marital problems: \_\_\_\_\_

Custody arrangements if applicable: \_\_\_\_\_

Who lives at home with this child? \_\_\_\_\_

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

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Please describe any conflict surrounding homework: \_\_\_\_\_

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Please describe how you discipline your child: \_\_\_\_\_

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**SOCIAL**

How many close friends does your child have? \_\_\_\_\_

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

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

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

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How many hours per day does your child watch TV and play video games? \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**SELF-ESTEEM**

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

**PAST MEDICAL HISTORY**

Was this child adopted?  Yes  No

**PREGNANCY**

Was this pregnancy planned?  Yes  No

<b>PREGNANCY COMPLICATIONS</b>	<b>Yes</b>	<b>No</b>
Bleeding		
Premature labor		
High blood pressure		
Toxemia		
Infections		
Weight gain less than 15 lbs.		
Diabetes		
Smoking		
Drug use *		
Alcohol use: # of drinks/day _____		
Emotional or family problems *		
Previous stillborns/miscarriages		

Specify any medications/drugs or other details:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**LABOR AND DELIVERY:**

Length of pregnancy: \_\_\_\_\_ Type of delivery:  Vaginal  Cesarean

Mother's age at delivery: \_\_\_\_\_

Complications:

- fetal distress (heart rate drop)
- meconium (bowel movement) passage before birth
- forceps use
- breech delivery
- other, describe \_\_\_\_\_

**NEWBORN HISTORY:**

Birth weight: \_\_\_\_\_ lbs. \_\_\_\_\_ oz.

Complications at birth (check those that apply):

- None
- Needed oxygen
- Difficulty breathing/respiratory distress
- Treated in an intensive care unit (NICU)
- Jaundice
- Low blood sugar
- Infection/ pneumonia
- Other: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**GROWTH**

Has your child had any problems with (if yes, please describe):

Weight loss or gain:  No  Yes: \_\_\_\_\_

Growth in height or length:  No  Yes: \_\_\_\_\_

Head size:  No  Yes: \_\_\_\_\_

Additional details or comments: \_\_\_\_\_

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**DEVELOPMENT**

Did your child's development seem normal compared to other children?  No  Yes

Developmental milestone	Age Achieved
Rolled over	
Sat alone	
Walked alone	
First words (mama-dada)	
Two word sentences	
Toilet trained – days	
Toilet trained – nights	
Dress self	

**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: \_\_\_\_\_

**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.

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

Father's age: \_\_\_\_\_

Mother's age: \_\_\_\_\_

Sister(s) name and ages: \_\_\_\_\_

Brother(s) name and ages: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**FAMILY HEART HISTORY:**

If a member of your child’s family has had any of these medical problems, please record their relationship to your child.

PROBLEM	NO	YES	RELATIONSHIP
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			
Wolf-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			

**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			

**CHILD’S MEDICAL HISTORY:**

Are immunizations up to date?  No  Yes (Please include a copy of current immunization records)

Describe any serious reactions: \_\_\_\_\_

List any known allergies to medications, foods, pollens or inhalants: \_\_\_\_\_

Describe any hospitalizations or surgery (date, reason, problems): \_\_\_\_\_

Describe or list any chronic or serious past illnesses (include dates, medications, etc.): \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**MEDICATIONS:**

Please list currently prescribed or over the counter medications taken and their doses:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**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)			



## 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



Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

<b>SYMPTOMS</b>	<b>NEVER</b>	<b>OCCASIONALLY</b>	<b>OFTEN</b>	<b>VERY OFTEN</b>
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

  

<b>PERFORMANCE</b>	<b>EXCELLENT</b>	<b>ABOVE AVERAGE</b>	<b>AVERAGE</b>	<b>SOMEWHAT OF A PROBLEM</b>	<b>PROBLEMATIC</b>
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:**

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**

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





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**

(Office 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

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Discharge Summary  Operative Report  Consultation  Immunizations  
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 History and Physical  X-Ray Report  X-Ray Image(s)  Clinic Visit  
 Progress Notes  Other: \_\_\_\_\_  
 Billing Information

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: \_\_\_\_\_.
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- **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: \_\_\_\_\_





## TEACHER SCHOOL PROGRESS INITIAL EVALUATION

(Teacher to Complete)

Child's Name: \_\_\_\_\_ Grade Level: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Teacher's Name: \_\_\_\_\_ Class Name/subject: \_\_\_\_\_ Class Time /Period: \_\_\_\_\_

SYMPTOMS	NEVER	OCCASIONALLY	OFTEN	VERY OFTEN
1. Fails to give attention to details or makes careless mistakes in schoolwork	0	1	2	3
2. Has difficulty sustaining attention to tasks or activities.	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 schoolwork (not due to oppositional behavior or failure to understand).	0	1	2	3
5. Has difficulty organizing tasks and activities.	0	1	2	3
6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort.	0	1	2	3
7. Loses things necessary for tasks or activities (school assignments, pencils, or books).	0	1	2	3
8. Is easily distracted by extraneous 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 in classroom or in other situations in which remaining seated is expected.	0	1	2	3
12. Runs about or climbs excessively in situations in which remaining seated is expected.	0	1	2	3
13. Has difficulty playing or engaging in leisure activities quietly.	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor".	0	1	2	3
15. Talks excessively.	0	1	2	3
16. Blurts out answers before questions have been completed.	0	1	2	3
17. Has difficulty waiting in line.	0	1	2	3
18. Interrupts or intrudes on others (butts into conversations/games).	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



Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

<b>SYMPTOMS</b>	<b>NEVER</b>	<b>OCCASIONALLY</b>	<b>OFTEN</b>	<b>VERY OFTEN</b>
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

  

<b>PERFORMANCE</b>	<b>EXCELLENT</b>	<b>ABOVE AVERAGE</b>	<b>AVERAGE</b>	<b>SOMEWHAT OF A PROBLEM</b>	<b>PROBLEMATIC</b>
<b>ACADEMIC PERFORMANCE</b>					
48. Reading – accuracy of work completed	1	2	3	4	5
49. Mathematics – accuracy of work completed	1	2	3	4	5
50. Written expression - accuracy of work completed	1	2	3	4	5
<b>CLASSROOM BEHAVIORAL PERFORMANCE</b>					
51. Relationships with peers	1	2	3	4	5
52. Following directions	1	2	3	4	5
53. Disrupting class	1	2	3	4	5
54. Assignment completion	1	2	3	4	5
55. Organizational skills	1	2	3	4	5

**COMMENTS:**

Please return this form to parents
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