UNIVERSITY OF CALIFORNIA, IRVINE
School of Medicine
Department of Pediatrics
Division of Developmental & Behavioral Pediatrics

UC Irvine Child Development School
19262 Jamboree Road Irvine, CA 92612
MAIN OFFICE: (949) 824-2343
FAX: (949) 824-8737

The UC Irvine Child Development School specializes in diagnosis, treatment and education of children and adolescents with atypical development. Our approach emphasizes non-pharmacological intervention for children who have difficulty managing their behavior and accessing curriculum. We offer psychological assessments and consultations, comprehensive psychoeducational and neuropsychological testing, and a variety of mental health services for affected children and their families.

In collaboration with the Orange County Health Care Agency and the Mental Health Service Act, we offer a conventional school-based educational experience augmented by in-classroom behavior management techniques, daily social-emotional training groups, and weekly parent coaching groups.

If you would like to schedule an appointment for consultation, enroll in community-based group courses, or apply for enrollment in the school programs, the enclosed materials will assist you in the process. **The information we receive from you will enable us to plan a thorough initial consultation**. The following enclosed forms must be returned **prior** your initial appointment:

PARENT PACKET to be completed by Mother/Father or legal guardian:

- ✓ ***Parental Consent for the Treatment of a Minor***
- ✓ ***New Patient Information Sheet***
- ✓ ***Child/Family History Questionnaire***
- ✓ ***Enclosed Rating Scales***

TEACHER PACKET to be given to your child's current teacher(s)

Please include **copies** of any of your child's previous psychological, neuropsychological, speech and language, and/or physical/occupational therapy evaluations (no original documents, please).

It is also helpful for us to receive copies of reports from school psychologists or assessments (e.g., IEP evaluations, 504 Plans), as many of your child's report cards as possible, and the results of annual standard achievement tests (e.g., Stanford-9 or STAR test results provided by the school).

TO CONFIRM SCHEDULED APPOINTMENTS, THIS PACKET MUST BE COMPLETED AND RETURNED WITHIN 3 BUSINESS DAYS OF YOUR VISIT (*current teacher ratings may arrive separately)***.**

PACKETS CAN BE RETURNED BY MAIL, E-MAIL, FAX, OR DELIVERED TO OUR OFFICE AT:

UC Irvine Health Child Development School
19262 Jamboree Road
Irvine, CA 92612
Fax: (949) 824-8737

UC IRVINE CHILD DEVELOPMENT SCHOOL Programs 2015-16:

The School Programs
For currently enrolled and School alum only
Early Intervention School Program (1st through 5th grades)
Middle School Program (currently accepting applications for grades 6-7)
Reading Enrichment Groups (grades 1-4 only)
Homework Club (Middle School only)
Alumni Summer Booster program

Community Transition Services
Introduction to Parenting Techniques
Family Social Skills Coaching
Individual Counseling
School Transitions Course
Junior Counselor Program

Assessment & Consultation
Psychoeducational Assessment
Neuropsychological Assessment
Teacher/School Consultation
Community Outreach Presentations

For more information: (949) 824-3028

The School Programs

The **UC Irvine Division of Developmental & Behavioral Pediatrics** provides behavioral health services in a unique school setting. Additionally, the **Orange County Healthcare Agency**, through the California Mental Health Services Act, provides financial support for families qualifying for assistance. This year-round program currently serves children in grades 1-8. The program incorporates daily group cognitive-behavioral training, classroom-based behavioral support, clinical case management, and a regular education curriculum adhering to California Common Core Standards and modified to meet the needs of the child with challenges in attention, productivity, self-regulation and social relationships. Additionally, there a number of supplemental services available to the children and families enrolled in the School programs. For information on this unique program please contact our intake coordinator Carol Reed; (949) 824-3028 or carol.reed@uci.edu

Community Transitional Services

Introductory Parenting Techniques Education Course: 8-week program that teaches parenting skills about specific behavioral strategies and techniques, with the end goal of designing a tailored behavioral intervention home program to manage children's behaviors and to enhance the quality of parent-child interactions. Parents learn to increase the frequency of desirable behaviors, while reducing unwanted behaviors, in their children (ages 6-12) through group discussions, role-playing, and home assignments. Group sessions meet one evening a week.

Family Social Skills Coaching Course (ages 5-7 and 8-11 WITH Parents): 8-week evening program that focuses on improving relationships through developing adaptive skills such as assertiveness, accepting, good sportsmanship, and frustration tolerance. This course includes a 1-hour intake visit, eight 90-min. group sessions, and required parent group sessions that meet concurrently with children's sessions.

Individual and/or Family Therapy: Therapy for children, adolescents, and/or adults in individual or group settings to address specific concerns and goals. With a range of theoretical orientations (e.g., cognitive-behavioral, systemic), therapeutic approaches are individually tailored to best meet clients' needs and expectations. Sessions may focus on enhancing problem-resolution and coping skills, self-monitoring, modeling, and social skills in addition to life-skills coaching.

Assessment & Consultation

Psychological Assessments: Personalized, psychodiagnostic evaluations that include a comprehensive review of an individual's developmental, behavioral, and psychological history along with identifying current emotional and/or behavioral problems. Clinical problems addressed include attention and concentration difficulties, behavioral/ school difficulties, and neurodevelopmental difficulties to help guide recommendations for treatment.

Psychoeducational Testing: Assessment of general intellectual and academic skills (e.g., reading skills), problem solving abilities, academic achievement, and individual learning strengths and weaknesses (up to 6 hours of testing, report included).

Neuropsychological Testing: In-depth comprehensive assessment of cognitive abilities such as intelligence, memory, sensory-perceptual and motor functions, visuospatial skills, and visual and auditory attention and information processing for suspected neuropsychological deficits. Assessment of emotional status or personality may also be included (up to 10 hours of testing, report included).

Teacher & School Consultation Services: Customized to meet the needs of a small or large group, we provide lectures and trainings for In-services and in-house teacher trainings aimed to better understand the classroom and educational needs of children with challenges in attention, productivity, self-regulation and social relationships.

Forensic Neuropsychological Evaluation Services are available for an hourly rate that applies to time spent in: record review; patient/family interviews; neuropsychological test administration, scoring and interpretation; preparations of reports; and depositions and court testimony (minimum 4-hour charge for court testimony). Liens against compensation that may come from litigation are not accepted.

PAYMENT POLICY

The UC Irvine Child Development School Programs are fee-for-services. Through the California Mental Health Services Act, limited funding is available to subsidize mental health clinical services. Additionally, through gifts from generous donors, limited funding may be available to assist families with financial need. The University of California aims to provide cutting edge services at an affordable cost. Although a comprehensive assessment is a significant expenditure, please bear in mind that this type of evaluation is the cornerstone of a treatment plan. If you feel you may qualify for financial assistance, please contact Tina Wippler at (949) 824-3763 or cwippler@uci.edu to inquire about the application process.

SCHOOL SERVICES	**FEES**
School Intake Assessment	$150 / 60 min.
Registration	$475/ annual
Grades 1-8 and Alumni Booster School Programs	$27,500/annual ($2,292 / month)
Individual Reading Support	$60/hour
Reading Club (grades 1-4)	$120/week

COMMUNITY TRANSITION SERVICES	**FEES**
Introductory Parenting Techniques Education Course	$115 / per session (8-90 min. session course)
Social Skills Group Initial Intake Visit	$100 (1 hour)
Family Social Skills Coaching or PACK Canine Assisted Groups	$125 / per session (8-90 min. session course)
Individual / Family Counseling	$175 / 60 minutes
Individual / Family Psychological Therapy	$200/60 minutes
Alumni Junior Counselor Program	$720 (3 week session)

ASSESSMENT & CONSULTATION SERVICES	**FEES**
Neuropsychological & Psychodiagnostic Assessment (full report included)	$250 / 60 min.
Teacher & School Consultation	fees vary
Forensic Neuropsychological Evaluation	$500/60 minutes

We do not bill health insurance companies for our services because of costs associated with collections. Instead, with documentation of a diagnosis, we can provide you with a *Professional Fee Billing Sheet* (super bill) to submit to your insurance provider for out-of-network reimbursement. Most insurers will cover a portion of your bill; some provide nearly full reimbursement, whereas others may provide minimal. Please contact your insurance provider to determine how your insurance plan reimburses for *outpatient mental/behavioral health services*. **We require all payments be made in full by cash, credit card, or a check (payable to "UC Regents") at the time of service.**

Billing for all sessions begins at the scheduled appointment time, so please allow for travel time. **Failure to cancel appointments at least one full business day in advance will result in a charge for the entire scheduled appointment. To cancel or reschedule an appointment in advance, please do so by calling (949) 824-2343.**

Fees are due at the time of appointment/session and are subject to change without notice. Please be advised that testing reports will not be mailed until your bill is paid in full.

Directions to UC Irvine CHILD DEVELOPMENT SCHOOL

19262 Jamboree Road
Irvine, CA 92612
(949) 824-2343

We are located on the northbound side of Jamboree Road, between Fairchild and Birch in Irvine, California (see map).

FROM THE 405 FREEWAY:

Turn South on Jamboree and proceed about 1.5 miles. Proceed south past Birch, and make U-turn at Fairchild. Proceed north and the facility will be on the right just before Birch. See further directions below.

FROM NEWPORT BEACH:

Go North on Jamboree past MacArthur Boulevard. Cross MacArthur, pass Fairchild and turn right into the facility. See further directions below.

FROM THE 73 FREEWAY GOING SOUTH:

Exit at Jamboree Road and turn left (North) onto Jamboree.

FROM THE 73 FREEWAY GOING NORTH:

Exit at MacArthur Boulevard. Proceed to Jamboree Road and turn right. Cross MacArthur, pass Fairchild and turn right at into the facility. See further directions below.

Parents: Please make sure your child arrives for psychoeducational/neuropsychological testing with a full night of sleep and bring a snack/lunch. If your appointment is taking place on a Saturday or Sunday, please be advised that the front doors may not be open until your specified appointment time.

University of California, Irvine
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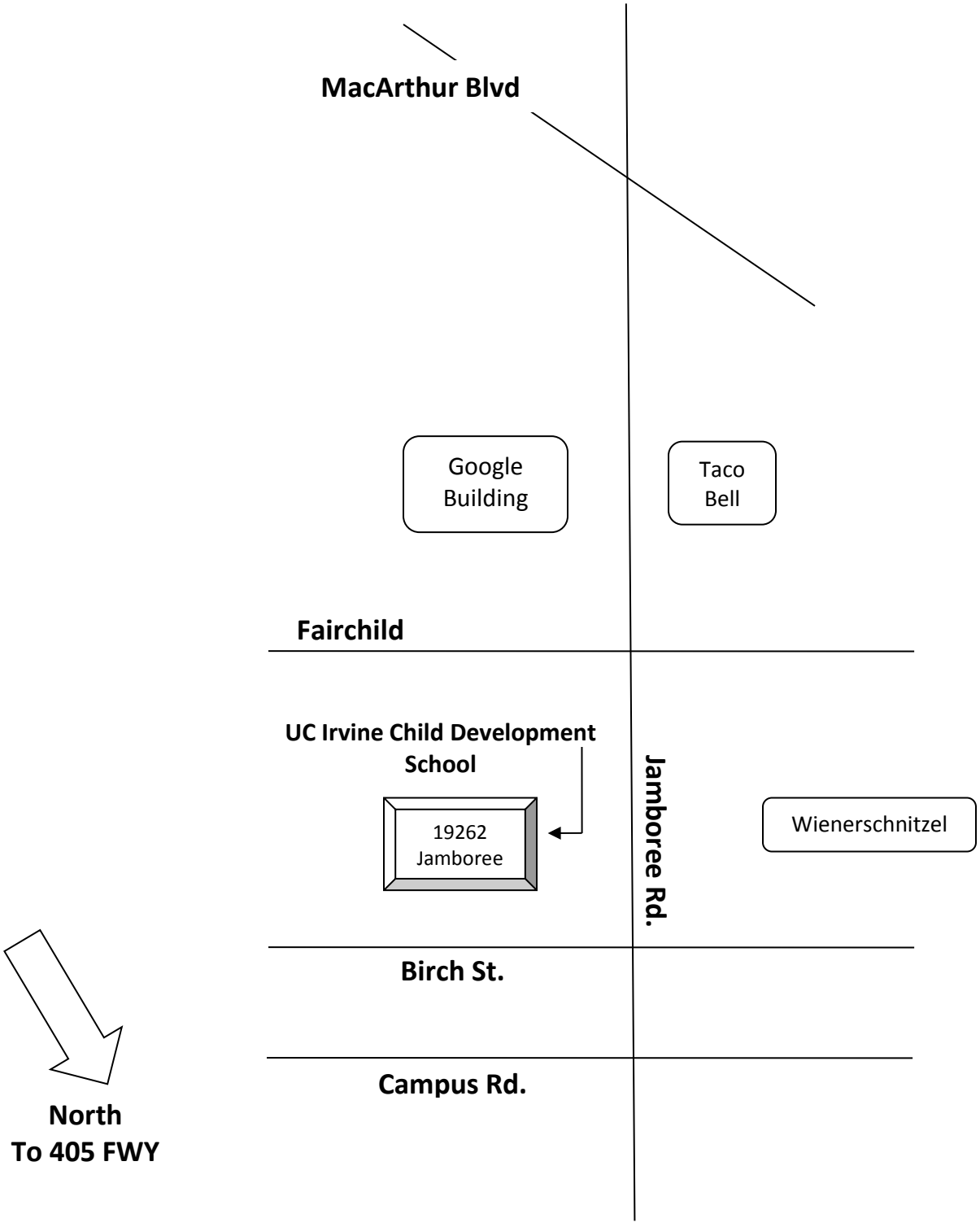

UC IRVINE CHILD DEVELOPMENT SCHOOL

New Patient Information Sheet

This sheet and pages 2-4 must be completed and returned within 3 business days prior to all initial appointments*

PATIENT (legal name): _____ **Age:** ___ **DOB:** ___/___/___ **Sex:** M / F

Home address _____**City**_____ **ZIP**_____

Social security #_____/____/____ **Home phone:** _____ **Cell:** _____

Current School _____ **Current Grade** ____ **Grade in Fall** _____

School District _____

MOTHER/Legal Guardian Name_____ **Date of birth**____/____/____

Home address (*if different from patient*)_____
Street City Zip

Social security #_____/_____/_____ Home phone: _____ Cell: _____

E-mail:_____ Work phone: _____ Employer:_____

Employer address_____ City_____ ZIP_____

Primary Contact Number (*check one*): ☐ Home ☐ Cell ☐ Work

FATHER/Legal Guardian Name_____ **Date of birth**____/____/____

Home address (*if different from patient*)_____
Street City Zip

Social security #_____/_____/_____ Home phone: _____ Cell: _____

E-mail:_____ Work phone: _____ Employer:_____

Employer address_____ City_____ ZIP_____

Primary Contact Number (*check one*): ☐ Home ☐ Cell ☐ Work

Name of emergency contact _____ Relationship to patient _____

Home address_____City_____ ZIP_____

Home phone: _____ Cell: _____ Work: _____

***If the parents (above) are legally divorced or separated, indicate the current court-ordered custody agreement:**

☐ Not Applicable – Parents are Married

☐ Joint (shared) Legal Custody *(details)*: _____

☐ Joint Physical Custody *(details):* _____

☐ Mother Sole (Full) Legal Custody

☐ Father Sole (Full) Legal Custody

☐ Other *(details):* _____

**Written consent from parent with sole legal custody for health care decisions or from both parents sharing legal custody is required prior to services for the above named minor to receive mental health examinations, diagnostic procedures, and/or treatment at the UC Irvine Child Development School.*

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PARENTAL CONSENT FOR THE MENTAL HEALTH TREATMENT OF A MINOR

Minor Name: _____ _____ _____
Last First Middle

Minor Date of Birth: ____/____/____

As the parent or legal guardian with the authority to consent on behalf of the minor named above, I authorize and request that my child receives psychological assessments, diagnostic procedures, and/or psychiatric treatment as deemed advisable and/or necessary by the professional staff of the University of California, Irvine Child Development School. I understand that the purpose of these procedures, proposed treatment plan, the general nature and extent of the risks involved in the treatment, and alternative treatment options, if any, will be explained to me.

My signature below indicates that I have read and fully understand this Consent for Treatment form.

_____ _____ ____/____/____
Print Name of Mother/Guardian Signature of Mother/Guardian Date

_____ _____ ____/____/____
Print Name of Father/Guardian Signature of Father/Guardian Date

Name of Parent Responsible for Payments and Fees: _____

Authorization: I understand that I am personally responsible for all payment/fee charges. I understand that all payment(s) are required in full at the time of service(s) by cash, credit card, or check payable to "UC Regents." In the event that I seek insurance reimbursement, and the UC Irvine Child Development School is contacted for verification of services, I authorize the UC Irvine Child Development School to provide necessary information requested by my insurance carrier. A copy of this authorization shall be considered as valid as the original.

_____ ____/____/____
Signature of Parent Responsible for Payment Date

UC IRVINE CHILD DEVELOPMENT SCHOOL

CHILD/FAMILY HISTORY QUESTIONNAIRE

Today's date: ____/____/____ **Completed by**: _____ **Relationship to child:**_____

INFORMATION ABOUT CHILD:

Name_____ **DOB**____/_____/____ **Age**_____ **Sex:** M / F
FIRST LAST MI

Current Grade_____ **Grade in Fall** _____ **School attending:**_____ **District**:_____

Child Ethnicity: *(select one)*

- ❑ Hispanic/Latino/Spanish origin
- ❑ Not Hispanic/Latino/Spanish origin
- ❑ Decline to state

Child Race: *(select one or more)*

- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Black or African American
- ❑ Native Hawaiian or Other Pacific Islander
- ❑ White
- ❑ Other: _____
- ❑ Decline to state

How did you learn of our services at the UCI Child Development School?_____

To whom were you referred / scheduled appointment with: _____

Purpose of your visit:

- ❑ Psychological Evaluation
- ❑ Psychoeducational or Neuropsychological Testing
- ❑ Family Therapy
- ❑ Individual Therapy / Coaching
- ❑ School Program (Specify Grade: _____)
- ❑ 8-week Parent Education Course
- ❑ 8-week Social Skills & Parent Coaching Course
- ❑ Consultation Services

Questions you would like to have answered by your visit: _____

_____

Primary behavioral / emotional / social / learning concerns you have about your child: _____

_____

_____

_____

What have you/teachers tried (e.g. accommodations) that has helped your child? _____

_____

CHILD'S FAMILY INFORMATION

With whom is this child currently living? *(check all that apply)*

- ❑ Biological mother
- ❑ Biological father
- ❑ Stepmother
- ❑ Stepfather
- ❑ Adoptive mother
- ❑ Adoptive father
- ❑ Foster mother
- ❑ Foster father
- ❑ Siblings
- ❑ Grandparent(s)
- ❑ Other relative(s)

Primary language spoken in the home, if other than English: _____

PARENTS WITH WHOM CHILD IS NOW LIVING:

MOTHER_____ **DOB**____/____/____ **Age** _____

Mother's highest level or degree of education completed: _____

Mother's current occupation:_____**Full Time___Part Time__**

FATHER_____ **DOB**____/____/____ **Age** _____

Father's highest level or degree of education completed: _____

Father's current occupation:_____ **Full Time___Part Time__**

The parents named above are: ❑ Married ❑ Separated ❑ Divorced ❑ Single (never married)

If not married, describe current court-ordered custody agreement for this minor: _____

_____

CHILD'S BROTHER(s): *(name)*

_____ Age____
_____ Age____
_____ Age____

CHILD'S SISTER(s): *(name)*

_____ Age____
_____ Age____
_____ Age____

Other persons living in the home: *(name)*

_____ Age_____ Relationship to child: _____

_____ Age ____ Relationship to child: _____

Biological parents *(if different than above)***:**

Mother_____ DOB_____ **Father** _____ DOB_____

Highest grade/degree completed _____ Highest grade/degree completed _____

Occupation_____ Occupation_____

FAMILY MEDICAL HISTORY:

Please list any major medical or psychiatric problems (e.g., epilepsy, ADHD, alcoholism, depression, learning disabilities, etc.) **in this child's immediate** (i.e., parents, siblings) **or extended family** (e.g., grandparents, aunt/uncle, cousins):

Relationship to child *(specify maternal or paternal)*	**Problem**	**Age of occurrence**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PREGNANCY AND NEONATAL HISTORY

Occurred During Pregnancy: *(check all that apply, indicate time of occurrence in weeks, and describe circumstances and/or associated complications)*

Time of occurrence (in weeks)

- ❑ Infections _____ *Describe:* _____
- ❑ Accidents _____ *Describe:* _____
- ❑ Medications _____ *Describe:* _____
- ❑ X-ray exposure _____ *Describe:* _____
- ❑ Toxic exposure _____ *Describe:* _____
- ❑ Alcohol or drug use _____ *Describe:* _____
- ❑ Tobacco (i.e., cigarette) use _____ *Describe:* _____
- ❑ Maternal emotional distress _____ *Describe:* _____
- ❑ Gestational diabetes _____ *Complications:* _____
- ❑ Toxemia _____ *Complications:* _____
- ❑ Fertility medication(s) _____ *Describe/Complications:* _____
- ❑ Artificial insemination _____ *Complications:* _____
- ❑ In-vitro fertilization _____ *Complications:* _____
- ❑ Other: _____ *Complications:* _____

DELIVERY:

Week of pregnancy when child was born: _____ **Birth weight:** _____lb _____oz

- ❑ Normal vaginal
- ❑ Vaginal, assisted with forceps or vacuum
- ❑ C-section, planned *(describe circumstances)* _____
- ❑ C-section, emergency *(describe circumstances)* _____
- ❑ Breech delivery

Duration of labor *(in hours)*:_____ **Type of anesthesia** *(if used)*:_____

APGAR scores: 1 min._____ 5 min._____

NEONATAL PROBLEMS: *(if checked, please describe)*

❑ Needed help breathing _____

❑ Cardiac/heart problem _____

❑ Severe infection _____

❑ Jaundice/high bilirubin _____

❑ Born addicted/exposed to alcohol or other drugs_____

❑ Required incubator _____

❑ Nursing/feeding problems/colic _____

❑ Bowel/urinary problems_____

❑ Other problems:_____

WAS BABY DISCHARGED WITH MOTHER? ❑ Yes ❑ No (*explain*):_____

NEONATAL NUTRITION:

Breast fed? ❑ No ❑ Yes: Exclusively breast fed from _____ to _____ months

Partially breast fed from _____ to _____ months

Formula fed? ❑ No ❑ Yes: Exclusively bottle fed from _____ to _____ months

Partially bottle fed from _____ to _____ months

Solid food began at _____ months

FOOD ALLERGIES: ❑ No ❑ Yes:_____

DEVELOPMENTAL MILESTONES – APPROXIMATE MONTH AT WHICH CHILD:

Sat up:_____ Babbled:_____ Fed self with spoon:_____ fork:_____

Crawled:_____ Spoke single words:_____ Ate neatly (minimum spillage):_____

Took first step:_____ Spoke 2 or 3 word sentences:_____ Fully toilet trained (occasional accidents):____

Walked unassisted:_____ Verbally related experiences: _____

COMMUNICATION

Has your child ever had any of these communication problems? *(check all that apply)*

❑ Delayed onset of speech

❑ Stuttering, stammering, or lisping

❑ Expressive aphasia/dysphasia/paraphasia (difficulty expressing him/herself)

❑ Receptive aphasia (difficulty understanding spoken words)

❑ Echolalia / stereotypic speech (automatic repetition of others' speech / repetitive or scripted statements)

❑ Auditory processing problems

❑ Other communication problems *(describe)* _____

If you checked any of the above communication problems, describe any treatment your child received:

Treatment	Provider	Duration / Frequency	Age Began / Age Ended
_____	_____	____hrs / ____ per week	___ yrs / ___ yrs
_____	_____	____hrs / ____ per week	___ yrs / ___ yrs
_____	_____	____hrs / ____ per week	___ yrs / ___ yrs

PERCEPTUAL AND MOTOR DEVELOPMENT

Child Handedness: ❑ Right ❑ Left ❑ Ambidextrous

Has your child ever had any of these problems? *(check all that apply)*

❑ Visual perceptual difficulties

❑ Cerebral palsy, spasticity, paralysis or dystonia

❑ Clumsiness, poor gross motor skills

❑ Poor fine-motor coordination

❑ Other perceptual/motor problems *(describe)* _____

If you checked any of the perceptual/motor development problems, describe any treatment:

Treatment	Provider	Duration / Frequency	Age Began / Age Ended
_____	_____	____hrs / ____ per week	___ yrs / ___ yrs
_____	_____	____hrs / ____ per week	___ yrs / ___ yrs
_____	_____	____hrs / ____ per week	___ yrs / ___ yrs

ILLNESSES/CONDITIONS SINCE BIRTH *(check all that apply since birth and provide details)*:

❑ Allergies *(specific type, eczema, medication/food, etc.)*:_____

_____

❑ Asthma: _____

❑ Operations: _____

❑ Hospitalizations: _____

❑ Meningitis/encephalitis: _____

❑ Head injuries: _____

❑ Seizures/convulsions: _____

❑ Vision problems: _____

❑ Hearing problems: _____

❑ Repeated ear infections: _____

❑ Required ear tubes: _____

❑ Heart problems: _____

❑ Breathing problems: _____

❑ Exposed to toxic chemicals: _____

CHILD'S CURRENT WEIGHT *(in pounds)*: _____

CHILD'S CURRENT HEIGHT: ____ft. ____in.

CHILD'S CURRENT HEALTH IS: ❑ Very poor ❑ Poor ❑ Fair ❑ Good ❑ Excellent

EMOTIONAL/BEHAVIORAL PROBLEMS

Has your child ever seen a provider at For OC Kids (Orange, CA)/Center for Autism and Neurodevelopmental Disorders (Santa Ana, CA)? ❑ No ❑ Yes

Has your child ever been formally evaluated for an emotional, behavioral, or learning disorder (e.g., depression, anxiety, ADHD, Autism/Asperger's disorder, learning disability)? ❑ No ❑ Yes:

Age	**Type of evaluation / Location:**	**Reason:**
____	_____	_____
____	_____	_____

Has your child ever been formally diagnosed with an emotional, behavioral, or learning disorder (e.g., depression, anxiety, ADHD, Autism/Asperger's disorder, learning disability)? ❑ No ❑ Yes:

Age	**Diagnosis:**	**Diagnosed by:**
____	_____	_____
____	_____	_____

Has your child ever received non-medication treatment (e.g., counseling/therapy, biofeedback) for emotional, behavioral, or learning problems? ❑ No ❑ Yes:

Type of Treatment	**Provider**	**Duration / Frequency**	**Age Began / Age Ended**
_____	_____	____hrs / ____ per week	___ yrs / ___ yrs
_____	_____	____hrs / ____ per week	___ yrs / ___ yrs
_____	_____	____hrs / ____ per week	___ yrs / ___ yrs

MEDICATION HISTORY

Medication ever used for *psychiatric reasons or behavior control* (e.g., ADHD, depression, aggression):

Medication	**Reason**	**Dosage(s)**	**Age began**	**Still used?**	**If no, duration of use:**
_____	_____	AM_____PM_____	_____yrs	❑ Yes ❑ No	____ months
_____	_____	AM_____PM_____	_____yrs	❑ Yes ❑ No	____ months
_____	_____	AM_____PM_____	_____yrs	❑ Yes ❑ No	____ months

Child's medication ever used for *GENERAL health conditions* (e.g., for asthma or allergies):

Medication	Reason	Dosage(s)	Age began	Still used?	If no, duration of use:
_____	_____	AM_____PM_____	_____yrs	❑ Yes ❑ No	____ months
_____	_____	AM_____PM_____	_____yrs	❑ Yes ❑ No	____ months
_____	_____	AM_____PM_____	_____yrs	❑ Yes ❑ No	____ months

ACADEMIC HISTORY

Current School: _____ District _____ Grade____

School Address_____ City_____ ZIP_____

Phone_____ Fax_____

Type of classroom: ❑ Regular (full) ❑ Regular (partial) ❑ Special Ed. ❑ Gifted ❑ RSP _____
❑ Other: _____

Has your child ever had any of these learning problems? *(check all that apply)*

❑ Dyslexia/alexia
❑ Difficulty in math/spatial relationships
❑ Difficulty in spelling
❑ Difficulty writing or printing
❑ Difficulty remembering lessons
❑ Takes an inordinately long time to finish homework, regardless of the subject or level of difficulty

If you checked one of the above learning problems, describe any treatment your child received:

Treatment	Provider	Duration / Frequency	Age Began / Age Ended
_____	_____	____hrs / ____ per week	___ yrs / ___ yrs
_____	_____	____hrs / ____ per week	___ yrs / ___ yrs
_____	_____	____hrs / ____ per week	___ yrs / ___ yrs

Has your child ever qualified for an Individualized Education Plan (IEP), 504 Plan, or received other school accommodations (e.g., modified assignments)? ❑ No ❑ Yes (*type, grade, details):*

_____

_____

_____

_____

Has your child ever repeated a grade? ❑ No ❑ Yes: Which grade?_____

Has your child ever been in a special education class? ❑ No ❑ Yes (*type of class, grade, reason):*_____

_____

Has your child ever been expelled/suspended? ❑ No ❑ Yes: *(age, reason)*_____

_____

Is your child currently experiencing social problems with his/her peers? ❑ No ❑ Yes: *(describe)*_____

_____

_____

_____

Chronology of school attendance:

Age	Grade	School	Specific Problems observed?
___	____	_____	_____
___	____	_____	_____
___	____	_____	_____
___	____	_____	_____
___	____	_____	_____
___	____	_____	_____
___	____	_____	_____

STRENGTHS

Questionnaires always seem to ask more about problems than about strengths. Please use the space below to describe, in your own words, the good characteristics and best qualities of your son/daughter. What do you like best about him/her? What are the things that he/she does that please you the most?

_____

_____

_____

_____

_____

_____

_____

UC IRVINE
PARENT RATINGS OF BEHAVIORAL COMPETENCIES

Child's name _____ **Today's Date:** ____/____/____

Completed by: *(primary caretaker, check one)* ❑ Mother ❑ Father ❑ Other _____

Print additional copies for second parent or guardian to complete and return.

Rate your child's ability on the items listed below, using the following scale.

1. **Very poorly**—worse than all but as few children this age
2. **Not too well**—most children this age do better (well below average)
3. **Fair**—better than some children this age but not as good as most (slightly below average)
4. **Fairly well**—better than many children this age (slightly above average)
5. **Good**—better than most children this age (well above average)
6. **Excellent**—better than all but a few children this age

COMPARED TO OTHER CHILDREN HIS/HER AGE, HOW WELL DOES YOUR CHILD PERFORM IN THE FOLLOWING AREAS?	Very poorly	Not too well	Fair	Fairly well	Good	Excellent
1. Paying attention when another person is speaking.....	1	2	3	4	5	6
2. Tolerating tasks that require sustained mental effort.....	1	2	3	4	5	6
3. Concentrating in the presence of distractions.....	1	2	3	4	5	6
4. Following through on instructions.....	1	2	3	4	5	6
5. Working at a steady pace.....	1	2	3	4	5	6
6. Organizing tasks before starting.....	1	2	3	4	5	6
7. Starting assignments on time.....	1	2	3	4	5	6
8. Staying on task for an entire class period.....	1	2	3	4	5	6
9. Completing assignments.....	1	2	3	4	5	6
10. Transitioning from one subject to the next.....	1	2	3	4	5	6
11. Thinking before acting.....	1	2	3	4	5	6
12. Telling the truth.....	1	2	3	4	5	6
13. Owning up to mistakes.....	1	2	3	4	5	6
14. Behaving affectionately towards parents.....	1	2	3	4	5	6
15. Gaining parental attention through positive efforts.....	1	2	3	4	5	6
16. Adhering to rules.....	1	2	3	4	5	6
17. Doing household/classroom chores.....	1	2	3	4	5	6
18. Keeping quiet while others are speaking.....	1	2	3	4	5	6
19. Respecting personal space of others.....	1	2	3	4	5	6
20. Remaining friendly and concerned for others.....	1	2	3	4	5	6

Parent Ratings of Behavioral Competencies (continued)

COMPARED TO OTHER CHILDREN HIS/HER AGE, HOW WELL DOES THIS CHILD PERFORM IN THE FOLLOWING AREAS?	Very poorly	Not too well	Fair	Fairly well	Good	Excellent
21. Waiting for turn in games.....	1	2	3	4	5	6
22. Subordinating personal needs to those of the group.....	1	2	3	4	5	6
23. Respecting others' personal property.....	1	2	3	4	5	6
24. Keeping hands off others.....	1	2	3	4	5	6
25. Avoiding quarrels.....	1	2	3	4	5	6
26. Controlling temper.....	1	2	3	4	5	6
27. Maintaining steady emotions (not too many highs or lows).	1	2	3	4	5	6
28. Enduring frustrations.....	1	2	3	4	5	6
29. Remaining cool and calm.....	1	2	3	4	5	6
30. Staying in a good mood.....	1	2	3	4	5	6
31. Staying relaxed and composed.....	1	2	3	4	5	6
32. Staying calm and even-tempered.....	1	2	3	4	5	6
33. Controlling the tendency to cry when provoked.....	1	2	3	4	5	6
34. Staying awake during the day.....	1	2	3	4	5	6
	Very poorly	Not too well	Fair	Fairly well	Good	Excellent
35. Maintaining a good sense of humor.....	1	2	3	4	5	6
36. Staying energetic.....	1	2	3	4	5	6
37. Remaining optimistic.....	1	2	3	4	5	6
38. Engaging enthusiastically in classroom or play activities....	1	2	3	4	5	6
39. Setting goals and objectives.....	1	2	3	4	5	6
40. Maintaining a realistic view of self.....	1	2	3	4	5	6
41. Thinking clearly while under pressure.....	1	2	3	4	5	6
42. Staying optimistic while searching for solutions.....	1	2	3	4	5	6
43. Producing neat work.....	1	2	3	4	5	6
44. Controlling fine motor movement (e.g., writing).....	1	2	3	4	5	6
45. Controlling gross muscular action (e.g., athletics, dancing)	1	2	3	4	5	6
46. Reacting quickly, but accurately.....	1	2	3	4	5	6
47. Maintaining balance when walking and running.....	1	2	3	4	5	6
48. Free hand drawing.....	1	2	3	4	5	6

SWAN Rating Scale (Swanson) – PARENT RATINGS

Child Name: _____ **Today's Date:** ____/____/____

Completed by: *(primary caretaker, check one)* ❑ Mother ❑ Father ❑ Other _____

Please print additional copies for second parent or guardian to complete and return.

Children differ in their abilities to focus attention, control activity, and inhibit impulses. For each item below, how does this child compare to other children of the same age? Select the best rating based on **your observations over the PAST MONTH. Compared to other children, how does this child do the following?**

Over the past month, my child…	**Far below**	**Below**	**Slightly below**	**Average**	**Slightly above**	**Above**	**Far Above**
1. Gives close attention to detail and avoids careless mistakes	1	2	3	4	5	6	7
2. Sustains attention on tasks or play activities.....	1	2	3	4	5	6	7
3. Listens when spoken to directly.....	1	2	3	4	5	6	7
4. Follows through on instructions; finishes school work/chores	1	2	3	4	5	6	7
5. Organizes tasks and activities.....	1	2	3	4	5	6	7
6. Engages in tasks that require sustained mental effort.....	1	2	3	4	5	6	7
7. Keeps track of belongings and items necessary for activities	1	2	3	4	5	6	7
8. Ignores extraneous stimuli (distractions).....	1	2	3	4	5	6	7
9. Remembers daily activities.....	1	2	3	4	5	6	7
	Far below	**Below**	**Slightly below**	**Average**	**Slightly above**	**Above**	**Far Above**
10. Sits still (controls movement of hands/feet or controls squirming).....	1	2	3	4	5	6	7
11. Stays seated (when required by class rules or social conventions).....	1	2	3	4	5	6	7
12. Controls motor activity (can stop inappropriate running or climbing).....	1	2	3	4	5	6	7
13. Plays quietly (keeps noise level reasonable).....	1	2	3	4	5	6	7
14. Settles down and rests (controls constant activity).....	1	2	3	4	5	6	7
15. Controls talking too much.....	1	2	3	4	5	6	7
16. Thinks before answering questions (controls blurting out answers).....	1	2	3	4	5	6	7
17. Waits for his/her turn (stands in line and takes turns).....	1	2	3	4	5	6	7
18. Enters into conversations and games (controls interrupting or intruding).....	1	2	3	4	5	6	7

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TEACHER PACKET

DEAR PARENT:

PLEASE GIVE THE FOLLOWING PAGES TO YOUR CHILD'S TEACHER. YOU MAY HAVE THE TEACHER RETURN THE COMPLETED FORMS TO YOU OR MAIL/FAX THEM DIRECTLY TO:

UC IRVINE
19262 Jamboree Road
IRVINE, CA 92612
FAX: (949) 824-8737

PLEASE MAKE COPIES FOR EACH TEACHER IF MORE THAN ONE (E.G., PRIMARY TEACHER AND RESOURSE TEACHER), AND FILL OUT THE REQUIRED INFORMATION (CHILD'S NAME) ON EACH FORM.

IF APPLICABLE, YOUR SCHOOL'S LEARNING SPECIALIST MAY BE ABLE TO ASSIST WITH DISTRIBUTING/COLLECTING TEACHER FORMS.

IF YOU DO NOT HAVE YOUR OWN COPIES OF THE FOLLOWING MATERIALS, PLEASE ASK THE SCHOOL TO HELP YOU GET THEM, AND SUBMIT COPIES OF THEM WITH THIS PACKET:

____ Reports of assessments/testing from school psychologists/counselors

____ IEP/504 reports

____ Report cards

____ Standardized academic test results (e.g., Stanford-9, STAR, ITBS)

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UNIVERSITY OF CALIFORNIA, IRVINE
School of Medicine
Department of Pediatrics
Division of Developmental & Behavioral Pediatrics

UC Irvine Child Development School
19262 Jamboree Road, Irvine, CA 92612
FAX: (949) 824-8737

Child's name: _____

Parent's name: _____

Dear Teacher:

We are requesting your help in assessing the learning and behavioral characteristics of the child named above. Teachers have an immensely important and unique perspective on their students, so your input is vital to a comprehensive assessment. The information you provide may be combined with test results and other observations of this child, and incorporated in a written diagnostic report that we hope will be of value for parents and teachers in their efforts to best meet the needs of this child.

Note: In the event that this child has more than one teacher, please feel free to duplicate these forms.

We thank you in advance for taking the time to complete the enclosed forms. They can be mailed or faxed directly to us at the address/fax shown above, or returned to the parent or learning specialist.

Sincerely,

UC Irvine Child Development School
Division of Developmental & Behavioral Pediatrics
Department of Pediatrics
School of Medicine
University of California, Irvine
Irvine, CA 92612
Office: (949) 824-2343
Fax: (949) 824-8737

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TEACHER RATINGS

SCHOOL PERFORMANCE AND ACHIEVEMENT

Today's date ____/____/____

Student's name_____ **Grade** _____

School name_____

Forms completed by (teacher's name):_____

Title:_____

Type of classroom (Regular, SDC, RSP, etc.):_____

Number of students in class:_____

How long has this student been in your class? _____ months

How many hours does this student spend in your class per week? _____ hours/week

How well do you know this student? ❑ Not at all ❑ Just a little ❑ Pretty much ❑ Very much

Please assess this student's academic or learning behaviors in your classroom. Compare this student with other students in the same classroom. Circle "1" if this student is in the lowest 10% of the class. Circle "5" if this student is in the highest 10% of the class.

	Lowest (10%) **1**	**Next Lowest** (20%) **2**	**Middle** (40%) **3**	**Next Highest** (20%) **4**	**Highest** (10%) **5**
1.	Compared with other students in your classroom, the **overall** academic performance of this student is:				**1 2 3 4 5**
2.	In terms of grade-level expectations, this student's skills in **reading** are:				**1 2 3 4 5**
3.	In terms of grade-level expectations, this student's skills in **mathematics** are:				**1 2 3 4 5**
4.	This student's overall **motivation** to succeed academically is:				**1 2 3 4 5**

Gresham & Elliott (2008)

Community Teacher Ratings of Intake Problem Behaviors

Note: Your input is important. We will be using the data that you provide below as a baseline measure of treatment effectiveness.

Please list the *Top Five* behaviors that interfere with success in your classroom. (You may draw from the list of common classroom problem behaviors on the next page.)

	Frequency *(please estimate the number of times each behavior occurs using either the hourly **OR** daily **OR** weekly **OR** monthly option that you think is most appropriate for the behavior) Indicate **a single numeric value (*not text*)** for each item in this Frequency section (see example).*				**Intensity** *(please estimate the severity of each behavior)*			
List the *Top Five* behaviors	Per hour	Per day	Per week	Per month	Not at all severe	Mildly severe	Moderately severe	Most severe possible
Example a *Physical aggression toward peers*	----	----	----	*1*	0	1	2	**3**
Example b *Cursing or swearing*	----	----	*2*	----	0	1	**2**	3
Example c *Blurting out*	*10*	----	----	----	0	1	2	**3**
1.					0	1	2	3
2.					0	1	2	3
3.					0	1	2	3
4.					0	1	2	3
5.					0	1	2	3

Please *describe* the top five behaviors listed above.

1.
2.
3.
4.
5.

Common Classroom Problem Behaviors

Difficulty following multiple step directions	Difficulty ignoring provocation	Blurting out
Refusal to follow directions	Cursing or swearing	Teasing peers, name calling, or disrespect for same age peers
Difficulty moving through transitions to other settings or activities	Destructive (e.g., ripping up homework, breaking pencils) with intent	Physical aggression toward peers
Difficulty sitting properly	Cries easily or frequently	Rudeness toward adults
Difficulty remaining seated	Hits himself/herself	Difficulty accepting consequences (e.g. whining, crying, negotiating)
Difficulty getting on task	Make negative statements about himself/herself	Overly shy and clings to caretaker/parent
Difficulty remaining on task	Difficulty making/maintaining eye contact	Overly silly with peers in play
Difficulty completing task	Difficulty greeting others	Talks too loud in play/conversation with peers
Rushing through tasks and making careless mistakes (e.g., spilling, neglecting to fasten clothing)	Overly concerned with others following the rules	Seems unaware of physical boundaries (e.g., hugs without permission, gets in 'bubble space')
Interrupting others in conversation	Must have things her/his way with peers in play	Other

UC IRVINE
TEACHER RATINGS OF BEHAVIORAL COMPETENCIES

TEACHER (name): _____ **Today's date** ____/____/____

Student's name_____

Rate this child's ability on the items listed below, using the following scale. *If you have not had an opportunity to observe the particular behavior, circle "n/a" (not applicable).*

1. **Very poorly**—worse than all but as few children this age
2. **Not too well**—most children this age do better (well below average)
3. **Fair**—better than some children this age but not as good as most (slightly below average)
4. **Fairly well**—better than many children this age (slightly above average)
5. **Good**—better than most children this age (well above average)
6. **Excellent**—better than all but a few children this age

n/a (not applicable)–no opportunity to observe this particular behavior

COMPARED TO OTHER CHILDREN HIS/HER AGE, HOW WELL DOES THIS CHILD PERFORM IN THE FOLLOWING AREAS?	Very poorly	Not too well	Fair	Fairly well	Good	Excellent
1. Paying attention when another person is speaking.....	1	2	3	4	5	6
2. Tolerating tasks that require sustained mental effort.....	1	2	3	4	5	6
3. Concentrating in the presence of distractions.....	1	2	3	4	5	6
4. Following through on instructions.....	1	2	3	4	5	6
5. Working at a steady pace.....	1	2	3	4	5	6
6. Organizing tasks before starting.....	1	2	3	4	5	6
7. Starting assignments on time.....	1	2	3	4	5	6
8. Staying on task for an entire class period.....	1	2	3	4	5	6
9. Completing assignments.....	1	2	3	4	5	6
10. Transitioning from one subject to the next.....	1	2	3	4	5	6
11. Thinking before acting.....	1	2	3	4	5	6
12. Telling the truth.....	1	2	3	4	5	6
13. Owning up to mistakes.....	1	2	3	4	5	6
14. Behaving affectionately towards parents.....	1	2	3	4	5	6
15. Gaining parental attention through positive efforts.....	1	2	3	4	5	6
16. Adhering to rules.....	1	2	3	4	5	6
17. Doing household/classroom chores.....	1	2	3	4	5	6
18. Keeping quiet while others are speaking.....	1	2	3	4	5	6
19. Respecting personal space of others.....	1	2	3	4	5	6
20. Remaining friendly and concerned for others.....	1	2	3	4	5	6

Teacher Ratings of Behavioral Competencies (continued)

COMPARED TO OTHER CHILDREN HIS/HER AGE, HOW WELL DOES THIS CHILD PERFORM IN THE FOLLOWING AREAS?	Very poorly	Not too well	Fair	Fairly well	Good	Excellent
21. Waiting for turn in games.....	1	2	3	4	5	6
22. Subordinating personal needs to those of the group.....	1	2	3	4	5	6
23. Respecting others' personal property.....	1	2	3	4	5	6
24. Keeping hands off others.....	1	2	3	4	5	6
25. Avoiding quarrels.....	1	2	3	4	5	6
26. Controlling temper.....	1	2	3	4	5	6
27. Maintaining steady emotions (not too many highs or lows).	1	2	3	4	5	6
28. Enduring frustrations.....	1	2	3	4	5	6
29. Remaining cool and calm.....	1	2	3	4	5	6
30. Staying in a good mood.....	1	2	3	4	5	6
31. Staying relaxed and composed.....	1	2	3	4	5	6
32. Staying calm and even-tempered.....	1	2	3	4	5	6
33. Controlling the tendency to cry when provoked.....	1	2	3	4	5	6
34. Staying awake during the day.....	1	2	3	4	5	6
	Very poorly	Not too well	Fair	Fairly well	Good	Excellent
35. Maintaining a good sense of humor.....	1	2	3	4	5	6
36. Staying energetic.....	1	2	3	4	5	6
37. Remaining optimistic.....	1	2	3	4	5	6
38. Engaging enthusiastically in classroom or play activities....	1	2	3	4	5	6
39. Setting goals and objectives.....	1	2	3	4	5	6
40. Maintaining a realistic view of self.....	1	2	3	4	5	6
41. Thinking clearly while under pressure.....	1	2	3	4	5	6
42. Staying optimistic while searching for solutions.....	1	2	3	4	5	6
43. Producing neat work.....	1	2	3	4	5	6
44. Controlling fine motor movement (e.g., writing).....	1	2	3	4	5	6
45. Controlling gross muscular action (e.g., athletics, dancing)	1	2	3	4	5	6
46. Reacting quickly, but accurately.....	1	2	3	4	5	6
47. Maintaining balance when walking and running.....	1	2	3	4	5	6
48. Free hand drawing.....	1	2	3	4	5	6

SWAN Rating Scale (Swanson) – TEACHER RATINGS

Student Name: _____

Teacher Name: _____ **Today's Date:** ____/____/____

Children differ in their abilities to focus attention, control activity, and inhibit impulses. For each item below, how does this child compare to other children of the same age? Select the best rating based on **your observations over the PAST MONTH. Compared to other children, how does this child do the following?**

	Far below	Below	Slightly below	Average	Slightly above	Above	Far Above
1. Gives close attention to detail and avoids careless mistakes	1	2	3	4	5	6	7
2. Sustains attention on tasks or play activities.....	1	2	3	4	5	6	7
3. Listens when spoken to directly.....	1	2	3	4	5	6	7
4. Follows through on instructions; finishes school work/chores	1	2	3	4	5	6	7
5. Organizes tasks and activities.....	1	2	3	4	5	6	7
6. Engages in tasks that require sustained mental effort.....	1	2	3	4	5	6	7
7. Keeps track of belongings and items necessary for activities	1	2	3	4	5	6	7
8. Ignores extraneous stimuli (distractions).....	1	2	3	4	5	6	7
9. Remembers daily activities.....	1	2	3	4	5	6	7
	Far below	**Below**	**Slightly below**	**Average**	**Slightly above**	**Above**	**Far Above**
10. Sits still (controls movement of hands/feet or controls squirming).....	1	2	3	4	5	6	7
11. Stays seated (when required by class rules or social conventions).....	1	2	3	4	5	6	7
12. Controls motor activity (can stop inappropriate running or climbing).....	1	2	3	4	5	6	7
13. Plays quietly (keeps noise level reasonable).....	1	2	3	4	5	6	7
14. Settles down and rests (controls constant activity).....	1	2	3	4	5	6	7
15. Controls talking too much.....	1	2	3	4	5	6	7
16. Thinks before answering questions (controls blurting out answers).....	1	2	3	4	5	6	7
17. Waits for his/her turn (stands in line and takes turns).....	1	2	3	4	5	6	7
18. Enters into conversations and games (controls interrupting or intruding).....	1	2	3	4	5	6	7

Based on your observations of and interactions with this child, please use the space below to describe his/her ***specific strengths and positive characteristics*.**

_____

_____

_____

_____

_____

_____

_____

_____

_____

Based on your observations of and interactions with this child, please use the space below to describe his/her ***behaviors or qualities that could be improved (e.g., behavioral, emotional, learning problems).***

_____

_____

_____

_____

_____

_____

_____

_____

_____