



State of Alaska
Pediatric Neurodevelopmental Outreach and Autism Screening Clinic

Child's Name: _____ Date of Birth: _____ Age: _____ M ___ F ___

Parent(s) or Guardian(s) Name(s) _____ In foster care? Y / N

Daytime phone: _____ Cell _____ Email: _____

Mailing Address _____ City _____ Zip _____

Primary Health Care Provider (s) _____ Name of school/Preschool _____

Clinic location: ___ Homer ___ Dillingham ___ Bethel ___ Fbks ___ Barrow ___ Kotzebue ___ Nome ___ Ketchikan ___ Juneau ___ Valdez ___ Kodiak

| Health Concerns | Y | N | Please explain concerns and any interventions |
|--|---|---|---|
| Problems with growth | | | |
| Vision or hearing concerns | | | |
| Sleep problems | | | |
| Chronic illnesses | | | |
| Developmental Concerns | Y | N | |
| Learning or cognitive delays | | | |
| Communication delays | | | |
| Motor delays | | | |
| Self-help delays (dressing, toileting) | | | |
| Problems with sharing | | | |
| Plays with other children often | | | |
| Likes to "pretend" play | | | |
| Behavioral Concerns | Y | N | Comments |
| Has frequent temper tantrums | | | |
| Aggressive towards self? Others? | | | |
| Extremely high or low activity level | | | |
| Poor attention control/distractible | | | |
| Plays with other children | | | |
| Happy most of the time | | | |
| Unusual fears | | | |
| Safety concerns/child fearless | | | |
| Routine bound | | | |
| Cries often | | | |

What services is your child receiving (please check all boxes):

- Early Intervention/Infant Learning
 Public Health Nursing
 OT
 PT
 Speech
 Mental Health Services
 Dietary
 Head Start
 Spec Ed preschool
 Spec Ed classroom
 Other _____
 Does child have IEP? Y / N

Please list others family members with a developmental concern:

What do you hope to gain from this assessment (Pls use reverse side to expand on concerns)?

Signed: _____ Relationship to child: _____ Date: _____