



UMass Memorial
Children's Medical Center

Early intervention/School Teacher Questionnaire

0-5 Packet

Child's Name: _____

Child's date of Birth: _____

Person completing form: _____

Relationship to the child: _____

School Name/Early Intervention Program Name:

Start Date for School/Early

Intervention: _____

Phone Number: _____

This child has been referred for a Developmental-Behavioral Pediatrics evaluation; your observations as this child's Early Intervention provider/teacher are a very important piece of this evaluation process.

Please return this questionnaire to your student's parents once completed:

1. Please describe this child's services (special education, early intervention, private services, classroom setting):

2. What are this child's strengths? _____

3. What are your main concerns? _____

4. Do you have concerns about this child's language development? Does this child have any unusual or repetitive vocalizations? If so, please describe: _____

5. Do you have any concerns about how this child communicates non-verbally, e.g., eye contact, pointing, waving, facial expressions and other gestures? If so, please describe:

6. Do you have any concerns about this child's social interactions with adults and/or other children: _____

7. Please describe how this child plays with toys and/or objects:

8. Does this child engage in pretend play? If so, is he/she imaginative or is the pretend play a repetition of others playing or of videos? _____

9. Are there any unusual or repetitive play patterns, such as lining up or spinning of toys, dumping and filling? _____

10. Does this child have a variety of play interests? _____

11. Does this child have any unusual mannerisms, e.g. hand flapping, an unusual way of looking at objects, finger movements, etc?

12. Do you have any concerns about this child's activity level, e.g. over or under active, or aggressivity? _____

Current Performance Survey	Not a Problem	Mild Problem	Moderate Problem	Serious Problem	Not sure
Overall Developmental Level					
Language Skills					
Fine Motor Skills					
Gross Motor Skills					
Cognitive Skills					
Self Help Skills					
Pre-Academic Skills					
Impulse Control					
Unusual Behaviors					
Aggression					
Cooperation					
Emotional Functioning					
Relationship with Adults					
Relationship with other Children					
Behavior Problems					

Is there any other information about the child, the family, school setting or the situation that would be helpful?

What do you think might help the child function better?

Once, completed, please return to:

Division of Developmental and Behavioral Pediatrics
Department of Pediatrics
Attn: Maribel Gonzalez
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55 Lake Avenue North, Worcester, MA 01655
Phone# 774-442-3028 Fax: 774-445-4229