TuftsMedicine
Pediatrics

CENTER FOR CHILDREN WITH SPECIAL NEEDS

Observer's Report Intake Form

School age

This form can be used by family members, teachers, classroom aides, tutors, therapists, child care providers or other observers as needed. Your observations are useful in understanding this child's current functioning in a variety of settings.

Child's Name _____ Date of birth _____

Person(s) completing this form _____ Grade _____

_____ Date _____

Relationship _____ Setting/subject _____

Address _____ Service provided _____

Address _____ Current medications _____

City, State, Zip Code _____ _____

Phone _____ Fax _____ _____

1. Please describe your main CONCERNS at this time: (behavior, attention span, academic skills, work habits, social skills, emotional responses, motor skills, etc.)

2. Please comment on this child's significant STRENGTHS:

3. What do you think might help this child function better?

4. How does this child do academically or perform in your setting? Please note grades, level of functioning, or results of testing.

Please indicate your estimate of this child's skill level below:

Subject	K	1	2	3	4	5	6	7	8	9	10	11	12
Reading	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Writing	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Math	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

5. Does this child have any health problems or take any medications for chronic or acute health problems?
   ☐ Don't know ☐ No ☐ Yes (please specify):

Does this child take medications for Attention-Deficit/Hyperactivity Disorder, emotional or behavioral problems:

☐ Don't know ☐ Never

☐ Medication in past (please specify) _____

☐ Current medication (please specify on front) _____

A. In your opinion, how helpful is the current medication for ADHD, emotional or behavioral problems:

☐ Don't know ☐ Very helpful ☐ Somewhat helpful ☐ No change ☐ Somewhat worse ☐ Much worse

B. Do you have any concerns about the current medication, timing, doses or possible side effects?

☐ Don't know ☐ No ☐ Yes (please specify):

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

Current Performance Survey	Not a Problem	Mild Problem	Moderate Problem	Serious Problem
Overall academic achievement (skills)?	☐	☐	☐	☐
Overall school performance (productivity, task completion)?	☐	☐	☐	☐
Overall home performance (ability do tasks, homework)?	☐	☐	☐	☐
Overall behavior?	☐	☐	☐	☐
Overall emotional functioning?	☐	☐	☐	☐
Relationships with adults?	☐	☐	☐	☐
Relationships with other children?	☐	☐	☐	☐
Relationship with adults?	☐	☐	☐	☐
Relationship with parents?	☐	☐	☐	☐
Relationships with other children?	☐	☐	☐	☐

CAP Rating Scale (Compare to other children of same age and sex)	Not True	Sometimes True			Often or Very True	
Fails to finish things he/she starts	☐ 0		☐ 1		☐ 2	
Can't concentrate, can't pay attention for long	☐ 0		☐ 1		☐ 2	
Daydreams or gets lost in his/her thoughts	☐ 0		☐ 1		☐ 2	
Difficulty following directions	☐ 0		☐ 1		☐ 2	
Messy work	☐ 0		☐ 1		☐ 2	
Inattentive, easily distracted	☐ 0		☐ 1		☐ 2	
Fails to carry out assigned tasks	☐ 0		☐ 1		☐ 2	
Total:						
Can't sit still or hyperactive	☐ 0		☐ 1		☐ 2	
Fidgets and squirms	☐ 0		☐ 1		☐ 2	
Impulsive or acts without thinking	☐ 0		☐ 1		☐ 2	
Talks out of turn	☐ 0		☐ 1		☐ 2	
Over reacts	☐ 0		☐ 1		☐ 2	
Total:						

Medication Status:
☐ On medication
☐ No medication
☐ Don't know