Mountain View Family Practice, PC
570 Baldwinville Rd. Baldwinville, MA 01436

Child's Name: ____ Today's Date: _________________
Child's DOB: _______________________

Name of Parent/Caretaker completing form: ____

Signature of Parent/Caretaker if declines behavioral screening:
____

1. Please list any concerns you have about your child's learning, development or behavior.

2. Do you have any concerns about how your child talks and/or makes speech sounds?

Circle one: No Yes A little Comments:

3. Do you have any concerns about how your child understands what your say?

Circle one: No Yes A little Comments:

4. Do you have any concerns about how your child uses his or her hands and fingers to do things?

Circle one: No Yes A little Comments:

5. Do you have any concerns about how your child uses his or her arms and legs?

Circle one: No Yes A little Comments:

6. Do you have any concerns about how your child behaves?

Circle one: No Yes A little Comments:

7. Do you have any concerns about how your child gets along with others?

Circle one: No Yes A little Comments:

8. Do you have any concerns about how your child is learning to do things for himself/herself?

Circle one: No Yes A little Comments:

9. Do yo have any concerns about how your child is learning preschool or school skills?

Circle one: No Yes A little Comments:

Please list any other concerns: