Name: _____

Allergies? _____ List known allergies: _____

Food Restrictions?_____ List restrictions:_____

Circle all that apply: **NO** food or liquids by mouth GTube GJ Tube

Does your child require assistance with any of the following? (**Circle** each item. If yes, please provide information.)

Eating/drinking: Yes No _____

Communication: Yes No _____

Does your child have any fears or anxieties? _____

How does your child handle change or transition? _____

_____

Does your child have any triggers or things that create frustration for them?	What coping skill does your child use or display?
○ Change in schedule ○ Someone touching them ○ Someone saying or doing something in particular ○ Working in a group ○ Making a mistake ○ Social situations (structured/unstructured) ○ Peer interactions ○ Over stimulating situations ○ Not getting instant gratification ○ Unstructured time ○ Making decisions/ having too many choices ○ When something unpredictable happens ○ Following directions ○ Staying on task ○ Not being first in line ○ Competitive situations(sports, games, etc) ○ Teasing ○ Other: Comments:	○ Shuts down ○ Tantrums ○ Throwing or ripping things ○ Physical aggression ○ Yells ○ Physical complaints (stomach or headache) ○ Challenges adult authority ○ Talks things out ○ Goes off quietly and calms down ○ Covers themselves with a blanket ○ Ignoring ○ Runs away ○ Walks ○ Drawing/coloring ○ Listens to music ○ Play-doh ○ Jumps ○ Uses stress ball ○ Writes ○ Other: Comments:
What anger cues does your child give when angry or frustrated? ○ Head pounding ○ Face gets red ○ Body shakes ○ Mad face ○ Stomach or headache ○ Eyes teary ○ Balled up fists ○ Nose flares ○ Verbal noises ○ Other:	Is there any other information that you would like for us to be aware of regarding your child? _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____