

Name \_

Age

Date \_

As a young child ages 1-5 were there any difficulties in the following areas. Please indicate Yes or No

- 1. APD or presumed APD in family yes no ? c
- 2. History of otitis media (ear fluid/infections?) (tubes?) yes no ? c
- 3. Allergies yes no ? c
- 4. Slow to learn to talk yes no ? d
- 5. Poor articulation yes no ? d
- 6. Limited vocabulary yes no ? d
- 7. 'Marches to a different drummer' yes no ? d+t
- 8. Poor language (receptive?) or (expressive?) yes no ? d/t
- 9. Not learn nursery rhymes yes no ? d+t
- 10. Difficulty with finger-play (e.g., itsy bitsy spider) yes no ? i+o
- 11. Bothered by noise yes no ? n
- 12. Makes own sounds (e.g., when ignition is turned on) yes no ? n
- 13. May be a noisy child when in noisy conditions yes no ? n
- 14. Hyperactive/wild when several children present yes no ? n
- 15. Easily distracted by noise yes no ? n
- 16. Forgetful yes no ? m
- 17. Does not remember simple directions yes no ? m
- 18. Messy, disorganized yes no ? o
- 19. Difficulty locating source of sounds yes no ? l
- 20. Has/had (sensory-integration?) or (speech?) therapy yes no ? i/d
- 21. Auditory training? \_\_\_\_\_ yrs
- 22. Speech therapy? \_\_\_\_\_ yrs
- 23. Phonological awareness training? \_\_\_\_\_ yrs
- 24. Special phonics training? \_\_\_\_\_ yrs
- 25. Reading therapy/tutoring? \_\_\_\_\_ yrs
- 26. ySensory-integration training? \_\_\_\_\_ yrs
- 27.

d-decoding; t-tolerance fading memory;n- noise intolerance; m-short term memory; i- integration; o- organization

Please expand or explain on any of these \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What other characteristics or events concerned you about the child's AP abilities?

\_\_\_\_\_

\_\_\_\_\_

Completed by: \_\_\_\_\_ Relation to Child: \_\_\_\_\_

For Office Use

D	N	M	T	TFM	I	O	C	L	Total