SOCIAL SKILLS DEVELOPMENT CENTER
DEMOGRAPHIC FORM

The following information will allow us to better help you. Please answer all items. ALL INFORMATION PROVIDED WILL REMAIN IN THE STRICTEST PROFESSIONAL CONFIDENCE.

CAREGIVER 1 LAST NAME_____, FIRST NAME_____

CAREGIVER 2 LAST NAME_____, FIRST NAME_____

Home Address_____City_____Zip_____

Home Phone ( )_____ Cell Phone ( )_____

Email Address:_____

ADULT LAST NAME_____, FIRST NAME_____

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1. Adult Gender ☐ Male ☐ Female

2. Adult Racial Background:
   ☐ Caucasian ☐ Latino/Hispanic
   ☐ African American ☐ Asian
   ☐ Native American ☐ Middle Eastern
   ☐ Other (specify) _____

3. Caregiver Current Marital Status:
   ☐ Unmarried ☐ Married
   ☐ Separated ☐ Divorced
   ☐ Widowed ☐ Living with partner

4. Children: Write in the name, sex, & birth date of each of your children. If adopted, put age at time of adoption.

Name	Sex	Birth Date

5. Does your adult have any problems with his/her behavior and/or academic adjustment in school?
   ☐ Yes ☐ No
   Specify: _____

6. Is your child in a special class of any kind?
   ☐ Yes ☐ No
   Specify: _____

7. Caregiver Occupation: Please write in the kind of work you most usually do using a "job title".
   _____

8. Number of hours per week employed: _____

9. Occupation of Spouse/Partner (even if separated/ divorced).
   _____

10. Number of hours per week employed: _____

11. Education: What were the highest levels in school or college completed? Or degrees obtained?
    Yourself: _____
    Spouse/Partner: _____

12. What is your goal for attending this program?
    _____
    _____
    _____

13. Who referred you to this program?

☐ Self ☐ Friend ☐ Brochure ☐ Website ☐ Professional:

Name: _____

Address: _____

_____

Phone ( ) _____

14. Is there any additional information we should have in order to help your family?

SOCIAL SKILLS DEVELOPMENT CENTER
MEDICAL SCREENING SUMMARY

Patient Name: _____
Caregiver(s) Name: _____
Relationship to Patient: _____
Primary Care Physician Name: _____
Address: _____ Phone: _____
May we contact physician if needed? ☐ Yes ☐ No
Has your child had psychological treatment/therapy before? ☐ Yes ☐ No
Therapist Name: _____
Address: _____ Phone: _____
May we contact therapist if needed? ☐ Yes ☐ No
Reason(s) for attendance in program: _____
_____
_____
_____
Name of School Patient Attends: _____ Grade: _____
Does your child have any medical condition(s)? ☐ Yes ☐ No
If yes, explain: _____

GESTATIONAL HISTORY

During this pregnancy did the mother have:	Yes	No	Describe:
Anemia	☐	☐	_____
Elevated blood pressure	☐	☐	_____
Swollen ankles	☐	☐	_____
Kidney diseases	☐	☐	_____
Heart disease	☐	☐	_____
Bleeding	☐	☐	_____
Measles	☐	☐	_____
German Measles	☐	☐	_____
Flu	☐	☐	_____
Other virus	☐	☐	_____
Other illness	☐	☐	_____
Vomiting	☐	☐	_____
Injury	☐	☐	_____
Medical during pregnancy	☐	☐	_____
Emotional problems	☐	☐	_____
Threatened miscarriage or early contractions	☐	☐	_____

In the 6 months preceding this pregnancy did the mother have exposure to:
Drugs or alcohol ☐ Yes ☐ No X rays ☐ Yes ☐ No
Describe: _____
_____
_____

PERINATAL HISTORY

	Yes	No	Describe:
Child premature	☐	☐	_____
Complicated labor	☐	☐	_____
Fetal distress	☐	☐	_____
Delayed crying	☐	☐	_____
Breech, Caesarian or forceps delivery	☐	☐	_____
Baby given oxygen or transfusion	☐	☐	_____
Baby placed in incubator	☐	☐	_____
Baby remained in hospital after mother went home	☐	☐	_____

DEVELOPMENT HISTORY

Were there any problems or delays in your child's:	Yes	No	Describe:
Holding head up	☐	☐	
Learning to bond	☐	☐	
Sitting alone	☐	☐	
Learning to crawl	☐	☐	
Sleeping through the night	☐	☐	
Learning to walk	☐	☐	
Learning to talk	☐	☐	
Toilet training	☐	☐	
Feeding self with spoon	☐	☐	
Tying shoes	☐	☐	
Dressing self	☐	☐	
Writing name	☐	☐	
Ability to make and get along with friends	☐	☐	
Other	☐	☐	
Is your child adopted?	☐	☐	If so, at what age? _____
Has your child ever been physically abused?	☐	☐	
Has your child ever been neglected?	☐	☐	
Has your child ever witnessed domestic violence?	☐	☐	
Has your child ever had someone close to him or her die?	☐	☐	

SCHOOL HISTORY:

Name of school child attends: _____ Grade Level: _____

Address & phone number of school: _____

Has your child ever had:	Yes	No	Describe:
Problems getting along with teachers	☐	☐	
Problems getting along with classmates	☐	☐	
Disruptive classroom behavior	☐	☐	
Suspensions/transfers	☐	☐	
Special education	☐	☐	
Failing grades	☐	☐	
Truancy	☐	☐	
Problems studying	☐	☐	
Special day classes	☐	☐	
Tutoring	☐	☐	
Other problems	☐	☐	

OTHER HISTORY:

Has your child ever:	Yes	No	Describe:
Been in trouble with the law	☐	☐	
Been removed from the family	☐	☐	
Been in a gang	☐	☐	
Been in foster care	☐	☐	
Used any weapons	☐	☐	
Experimented with sex or drugs	☐	☐	

MEDICAL HISTORY:

Does your child have any allergies? ☐ Yes ☐ No Allergic to: _____

Name of your child's doctor: _____

Address: _____ Date of last exam: _____

Phone: _____

MEDICAL HISTORY (continued)

Has your child even been hospitalized? ☐ Yes ☐ No If so, reason: _____

Has your child had any of the following:	Yes	No	Describe:
Chicken Pox	☐	☐	
Mumps	☐	☐	
Measles	☐	☐	
Tuberculosis	☐	☐	
Meningitis	☐	☐	
Polio	☐	☐	
Rubella	☐	☐	
Rheumatic Fever	☐	☐	
Hepatitis	☐	☐	
Parasites	☐	☐	
Other	☐	☐	

Has your child had any of the following immunizations?

☐ Polio ☐ DTP ☐ Measles ☐ MMR (Measles, Mumps, Rubella) ☐ Hepatitis B

Has your child had any of the following medical conditions?	Yes	No	Describe:
Birth defects	☐	☐	
High blood pressure	☐	☐	
Stomach problems	☐	☐	
Head injury	☐	☐	
Dizziness or fainting	☐	☐	
Asthmas, Hay Fever, Hives, Rash	☐	☐	
Kidney problems	☐	☐	
Surgeries, serious illnesses, accidents	☐	☐	
Epilepsy, convulsions, seizures	☐	☐	
Frequent, severe headache	☐	☐	
Back, muscle, joint problems	☐	☐	
Eating disorder	☐	☐	
Hepatitis, Jaundice or Liver problems	☐	☐	
Pregnancy	☐	☐	
Bedwetting	☐	☐	
Soiling	☐	☐	
Sleep problems	☐	☐	
Speech problems	☐	☐	
Diabetes	☐	☐	
Hearing impairment	☐	☐	
Vision impairment	☐	☐	
Other	☐	☐	

Does your child exhibit any of the following behaviors or problems?	Yes	No	Describe:
Problems with reading	☐	☐	
Problems with math	☐	☐	
Problems with writing skills	☐	☐	
Poor coordination	☐	☐	
Problems expressing him/herself	☐	☐	
Speech problems	☐	☐	
Problems understanding others	☐	☐	

Does your child exhibit any of the following behaviors or problems? (continued)	Yes	No	Describe:
Inattentiveness	☐	☐	
Hyperactivity	☐	☐	
Aggression towards others	☐	☐	
Destruction of property	☐	☐	
Stealing	☐	☐	
Lying	☐	☐	
Defiance	☐	☐	
Loses temper often	☐	☐	
Argues excessively	☐	☐	
Often breaks rules	☐	☐	
Blames others for his/her mistakes & misbehaviors	☐	☐	
Uses drugs or alcohol	☐	☐	
Tics	☐	☐	
Unable to control bowels	☐	☐	
Wets the bed	☐	☐	
Has trouble being alone	☐	☐	
Has trouble being away from home	☐	☐	
Refuses to talk	☐	☐	
Appears depressed	☐	☐	
Mood swings	☐	☐	
Appears anxious or fearful	☐	☐	
Sleep difficulties	☐	☐	
Nightmares	☐	☐	
Problems expressing affection	☐	☐	
Obsesses about things	☐	☐	
Cries easily/often	☐	☐	

Has your child been diagnosed with any of the following disorders? If yes, what year?	Yes	No	Describe:
Attention Deficit Hyperactivity Disorder (ADHD or ADD)	☐	☐	
Learning disability	☐	☐	
Speech or language delays	☐	☐	
Autism	☐	☐	
Depression	☐	☐	
Pervasive Development Disorder (PDD)	☐	☐	

FAMILY HISTORY:

Has anyone in your family had any of the following mental health conditions?	Yes	No	Describe:
Drug abuse	☐	☐	
Alcohol abuse	☐	☐	
Depression	☐	☐	
Suicide threats or attempts	☐	☐	
Completed suicide	☐	☐	
Anxiety Disorder/Panic Attacks	☐	☐	
Schizophrenia	☐	☐	
Attention Problems	☐	☐	
Learning Disabilities	☐	☐	
Manic Depression (Bipolar)	☐	☐	
Psychiatric Hospitalization	☐	☐	
Psychiatric medications	☐	☐	
Therapy or counseling	☐	☐	

Child's Name:_____

Completed By:_____

Medication History Questionnaire

☐ My child has never been on medications for behavior, mood, or attention (leave the rest of form blank).
☐ My child does not take medications at this time, but has in the past (please complete Part II).

Part I. If your child is currently taking prescription medication(s) for behavior, mood, or attention problems, please complete the following items for each medication your child is currently prescribed:

Current prescription medication #1 –Name of Medication_____
Total dosage taken per day_____mg
Approximate Date Prescribed:_____ Approximate Date Discontinued _____

1. Please check all problems this medication was supposed to address (check all that apply):
☐ Inattention ☐ Hyperactivity ☐ Aggression ☐ Tics ☐ Poor Social Skills ☐ Irritability ☐ Obsessions
☐ Poor Body Boundaries ☐ Anxiety ☐ Depressed Mood ☐ Difficulty with Transitions ☐ Explosiveness
☐ not sure which of the above.
☐ Other _____

2. AFTER prescribing the medication, how did the doctor check up on the problem later? Check all that apply:
☐ The doctor did not ask further questions.
☐ Asked parent about problem
☐ Asked child's teacher about problem
☐ Gave parent a form to complete about problem
☐ Gave child's teacher a form to complete about problem
☐ Asked child about problem
☐ Had parent ask child's teacher about problem
☐ Gave child a form to complete about problem
☐ The doctor asked only about side effects, not improvement in problem.
☐ Other (please indicate how) _____

3. Who prescribed it? ☐Pediatrician ☐Psychiatrist ☐Neurologist ☐Other Physician

4. Was this physician your current prescribing physician? ☐ Yes ☐ No

Please consider the effectiveness of this medication in addressing the above problem(s), without regard for any side effects.

5. How effective was this medication INITIALLY in reducing problems in your child?

1	2	3	4	5	6	7
Ineffective			Not sure			Very effective

6. How effective was this medication AT THE PRESENT TIME in reducing problems in your child?

1	2	3	4	5	6	7
Ineffective			Not sure			Very effective

Current prescription medication #2 – Name of Medication_____
Total dosage taken per day_____mg
Approximate Date Prescribed:_____ Approximate Date Discontinued _____

1. Please check all problems this medication was supposed to address (check all that apply):
☐ Inattention ☐ Hyperactivity ☐ Aggression ☐ Tics ☐ Poor Social Skills ☐ Irritability ☐ Obsessions
☐ Poor Body Boundaries ☐ Anxiety ☐ Depressed Mood ☐ Difficulty with Transitions ☐ Explosiveness
☐ not sure which of the above.
☐ Other _____

2. AFTER prescribing the medication, how did the doctor check up on the problem later? Check all that apply:
☐ The doctor did not ask further questions.
☐ Asked parent about problem
☐ Asked child's teacher about problem
☐ Gave parent a form to complete about problem
☐ Gave child's teacher a form to complete about problem
☐ Asked child about problem
☐ Had parent ask child's teacher about problem
☐ Gave child a form to complete about problem

☐ The doctor asked only about side effects, not improvement in problem.
☐ Other (please indicate how) _____

3. Who prescribed it (check one)? ☐ Same physician as Current medication #1 ☐Pediatrician ☐Psychiatrist ☐Neurologist ☐Other Physician

4. Was this physician your current prescribing physician? ☐ Yes ☐ No

5. Why was this medication added to medication #1? ☐ Medication #1 not effective enough ☐ This medication addressed a different problem ☐ Doctor did not specify ☐ Do not recall
☐ Other (please indicate)_____

Please consider the effectiveness of this medication in addressing the above problem(s), without regard for any side effects.

6. How effective was this medication INITIALLY in reducing problems in your child?

1	2	3	4	5	6	7
Ineffective			Not sure			Very effective

7. How effective was this medication AT THE PRESENT TIME in reducing problems in your child?

1	2	3	4	5	6	7
Ineffective			Not sure			Very effective

My child is prescribed _____ medications in addition to the above
Please list them
_____

<u>Part II.</u> Medications that your child has taken in the past. Please begin with the MOST RECENT medication that was discontinued and work backwards in time.
Past Medication #1 – Name of Medication_____Total dosage taken per day_____mg
Approximate Date Prescribed:_____ Approximate Date Discontinued _____

1. Please check all problems this medication was supposed to address (check all that apply):
☐ Inattention ☐ Hyperactivity ☐ Aggression ☐ Tics ☐ Poor Social Skills ☐ Irritability ☐ Obsessions
☐ Poor Body Boundaries ☐ Anxiety ☐ Depressed Mood ☐ Difficulty with Transitions ☐ Explosiveness
☐ not sure which of the above.
☐ Other _____

2. AFTER prescribing the medication, how did the doctor check up on the problem later? Check all that apply:
☐ The doctor did not ask further questions.
☐ Asked parent about problem
☐ Asked child's teacher about problem
☐ Gave parent a form to complete about problem
☐ Gave child's teacher a form to complete about problem
☐ Asked child about problem
☐ Had parent ask child's teacher about problem
☐ Gave child a form to complete about problem
☐ The doctor asked only about side effects, not improvement in problem.
☐ Other (please indicate how) _____

3. Who prescribed it? ☐Pediatrician ☐Psychiatrist ☐Neurologist ☐Other Physician

4. Was this physician your current prescribing physician? ☐ Yes ☐ No

5. Why was the medication discontinued? ☐ Side effects were problematic ☐ Medication no longer effective
☐ Doctor recommended a change to increase effectiveness ☐ Doctor did not specify ☐ Do not recall
☐ Other (please indicate)_____

Please consider medication effectiveness at addressing the above problem(s), without regard for any annoying or unbearable side effects.

6. How effective was this medication INITIALLY in reducing problems in your child?

1	2	3	4	5	6	7
Ineffective			Not sure			Very effective

7. How effective was this medication AT THE TIME YOU DISCONTINUED in reducing problems in your child?

1	2	3	4	5	6	7
Ineffective			Not sure			Very effective

Past Medication #2 – Name of Medication_____Total dosage taken per day_____mg
Approximate Date Prescribed:_____ Approximate Date Discontinued _____

1. Please check all problems this medication was supposed to address (check all that apply):
☐ Inattention ☐ Hyperactivity ☐ Aggression ☐ Tics ☐ Poor Social Skills ☐ Irritability ☐ Obsessions
☐ Poor Body Boundaries ☐ Anxiety ☐ Depressed Mood ☐ Difficulty with Transitions ☐ Explosiveness
☐ not sure which of the above.
☐ Other _____

2. AFTER prescribing the medication, how did the doctor check up on the problem later? Check all that apply:
☐ The doctor did not ask further questions.
☐ Asked parent about problem
☐ Asked child's teacher about problem
☐ Gave parent a form to complete about problem
☐ Gave child's teacher a form to complete about problem
☐ Asked child about problem
☐ Had parent ask child's teacher about problem
☐ Gave child a form to complete about problem
☐ The doctor asked only about side effects, not improvement in problem.
☐ Other (please indicate how) _____

3. Who prescribed it? ☐Pediatrician ☐Psychiatrist ☐Neurologist ☐Other Physician

4. Was this physician your current prescribing physician? ☐ Yes ☐ No

5. Why was the medication discontinued? ☐ Side effects were problematic ☐ Medication no longer effective
☐ Doctor recommended a change to increase effectiveness ☐ Doctor did not specify ☐ Do not recall
☐ Other (please indicate)_____

Please consider medication effectiveness at addressing the above problem(s), without regard for any annoying or unbearable side effects.

6. How effective was this medication INITIALLY in reducing problems in your child?

1	2	3	4	5	6	7
Ineffective			Not sure			Very effective

7. How effective was this medication AT THE TIME YOU DISCONTINUED in reducing problems in your child?

1	2	3	4	5	6	7
Ineffective			Not sure			Very effective

Other medications prescribed in the past ☐ yes ☐ no
Please list them:

_____

_____

Child Name: _____ Date: _____

Completed By: ☐ Mother ☐Father ☐Other: _____

BARKLEY PARENT QUESTIONNAIRE
(from Barkley Parent Interview)

Please answer the following to the best of your knowledge:

School name: _____

SCHOOL HISTORY

School Performance/Behavior

At any time has your child: (CHECK BOX, IF APPLICABLE, FOR EACH GRADE LEVEL)

GRADE LEVEL >>>	P	K	1	2	3	4	5	6	7	8	9	10	11	12
Undergone an IEP (school)														
Had Spec. Education Services														
Been labeled LD														
Worked below potential														
Failed a subject														
Repeated a grade														
Had ADHD problems														
Was defiant/argumentative														
Been suspended														
Been expelled														
Had peer problems														

Current Educational Program

1. What is your child's current grade level? _____

2. Is child now receiving Special Education Services? NO YES
   If yes, what type? (check all that apply)

- ☐ Resource room (part time)
- ☐ Shadow or Aide
- ☐ Occupational therapy
- ☐ Self-contained LD room (full time)
- ☐ Social skills group therapy
- ☐ Speech/language therapy
- ☐ School counseling
- ☐ Behavior disorders classroom
- ☐ Physical therapy
- ☐ Other _____

FAMILY HISTORY

Custody of child is held (if applicable):

- ☐ jointly
- ☐ by mother only
- ☐ by father only
- ☐ by state
- ☐ other _____

Psychiatric/Medical Characteristics of Biological Relatives

(CHECK ALL THAT APPLY) >>> Past/present history of the following in your family:	Siblings	Mother	Father	Extended (Maternal)	Extended (Paternal)
1. Short attention, distractibility, hyperactivity					
2. Defiant, rebellious, oppositional					
3. Lying, fighting, stealing, breaking rules					
4. Antisocial behavior					
5. Learning Disabilities or language difficulty					
6. Mental Retardation					
7. losing touch with reality					
8. Manic-depression					
9. Depression or suicide/attempted suicide					
10. "Nervous breakdown"					
11. Excessive fears (Phobias)					
12. Motor + vocal tics; Tourettes					
13. Alcohol abuse					
14. Substance abuse					
15. Physical abuse					
16. Sexual abuse					
17. Seizures/epilepsy					
18. Other medical					
19. Other psychiatric					
20. Outpatient psychiatric services					
21. Inpatient psychiatric services					

Lifestyle Changes/Psychosocial Stressors (in the past 6 months-1 year)
(Check all that apply)

- ☐ Pregnancy
- ☐ Change in work schedule
- ☐ New sibling
- ☐ Change in residence
- ☐ Marriage
- ☐ Change in school placement
- ☐ Severe marital tensions
- ☐ Job termination/layoff
- ☐ Separation/divorce
- ☐ Serious financial strains
- ☐ Health problems
- ☐ Serious legal problems
- ☐ Death of close relative/friend
- ☐ Psychiatric problems
- ☐ Other _____

Scored: _____ Pre Post

Verified: _____ Name: _____

Entered: _____ Date: _____

Quality of Socialization Questionnaire – Parent (QSQP-Revised)

We are interested in get-togethers that your teen had in the last month with other teens about the same age. A get-together is any time that teens follow through with a commitment to meet together after agreeing on a place and time.

- It may be a planned activity, such as bowling or at the video arcade or just to "hang out".
- It may be organized well in advance or organized spontaneously for later the same day.
- It may be with one other teen or a group of teens.

Please answer the following questions about your teen's get-togethers.

1. **Get-togethers your teen organized with another teen or other teens:** How many get-togethers were **organized by your teen in the past month**: _____

Please give the **first names** of the friends that attended a get-together **organized by your teen in the past month**. If your teen did not organize a get-together in the past month, leave the section below blank.

Friend's first name _____ Friend's first name _____

Friend's first name _____ Friend's first name _____

Friend's first name _____ Friend's first name _____

Friend's first name _____ Friend's first name _____

2. **Get-togethers at your home when you were present or that you chaperoned and were able to observe:** At the **last get-together your teen organized,** when **you could see or hear what was happening, how did the teens get along? Circle** the number below that describes how true each sentence is.

	Not at all true	*Just a little true*	*Pretty much true*	*Very much true*
They didn't share games, personal items, etc.	0	1	2	3
They got along well	3	2	1	0
They got upset at each other	0	1	2	3
They had fun	3	2	1	0
They argued with each other	0	1	2	3
They enjoyed each other	3	2	1	0
They criticized or teased each other	0	1	2	3
They shared conversation	3	2	1	0
They were bossy with each other	0	1	2	3
They needed a parent to solve problems	0	1	2	3
They withdrew from each other	0	1	2	3
They annoyed each other	0	1	2	3

3. **Get-togethers your teen was invited to by another teen or other teens:** How many get-togethers was your teen **invited to by others** in the **past month**: _____

Please give the **first names** of the teens who invited your teen to the get-togethers. If your teen did not attend a get-together organized by another teen in the past month, leave the section below blank.

Friend's first name _____ Friend's first name _____

Friend's first name _____ Friend's first name _____

Friend's first name _____ Friend's first name _____

Friend's first name _____ Friend's first name _____

Scored: _____ Pre Post

Verified: _____ Name: _____

Entered: _____ Date: _____

Please rate your child's behavior below. Please note: If your child is currently taking medication please answer the questions below according to your child's behavior when they are off the medication.

SNAP-IV RATING SCALE

James M. Swanson, Ph.D

Check the column which best describes this child:	Not at All	Just a Little	Pretty Much	Very Much
1. Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities				
2. Often has difficulty sustaining attention in tasks or play activities				
3. Often does not seem to listen when spoken to directly				
4. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)				
5. Often has difficulty organizing tasks and activities				
6. Often avoids, dislikes, or has difficulties engaging in tasks that require sustained mental effort (such as schoolwork or homework)				
7. Often loses things necessary for tasks or activities (e.g., school assignments, pencils, books, tools, or toys)				
8. Is often easily distracted by extraneous stimuli				
9. Often forgetful in daily activities				
10. Often fidgets with hands or feet, squirms in seat				
11. Often leaves seat in classroom or in other situations in which remaining seated is expected				
12. Often runs about or climbs excessively in situations where it is inappropriate				
13. Often has difficulty playing or engaging in leisure activities quietly				
14. Is always "on the go" or acts if "driven by a motor"				
15. Often talks excessively				
16. Often blurts out answers to questions before the questions have been completed				
17. Often has difficulty awaiting turn				
18. Often interrupts or intrudes on others (e.g., butts into other's conversations or games)				
19. Often loses temper				
20. Often argues with adults				
21. Often actively defies or refuses adult requests or rules				
22. Often deliberately does things that annoy other people				
23. Often blames others for his or her mistakes or misbehavior				
24. Often touchy or easily annoyed by others				
25. Is often angry and resentful				
26. Is often spiteful or vindictive				

Office Use Only:			
Total item ratings =	_____/9	_____/9	_____/8
Avg rating per item =	_____	_____	_____

Scored: _____

Verified: _____

Entered: _____

Pre Post

Name: _____

Date: _____

AQ

How to fill out the questionnaire

Below is a list of statements about your child. Please read each statement very carefully and rate how strongly you agree or disagree by selecting the appropriate option opposite each question.

DO NOT MISS ANY STATEMENT OUT.

Examples

E1. S/he is willing to take risks.	definitely agree	slightly agree	slightly disagree	definitely disagree
E2. S/he likes playing board games.	definitely agree	slightly agree	slightly disagree	definitely disagree
E3. S/he finds learning to play musical instruments easy.	definitely agree	slightly agree	slightly disagree	definitely disagree
E4. S/he is fascinated by other cultures.	definitely agree	slightly agree	slightly disagree	definitely disagree

	Definitely Agree	Slightly Agree	Slightly Disagree	Definitely Disagree
1. S/he prefers to do things with others rather than on her/his own.				
2. S/he prefers to do things the same way over and over again.				
3. If s/he tries to imagine something, s/he finds it very easy to create a picture in her/his mind.				
4. S/he frequently gets so strongly absorbed in one thing that s/he loses sight of other things.				
5. S/he often notices small sounds when others do not.				
6. S/he usually notices car number plates or similar strings of information.				
7. Other people frequently tell her/him that what s/he has said is impolite, even though s/he thinks it is polite.				
8. When s/he is reading a story, s/he can easily imagine what the characters might look like.				
9. S/he is fascinated by dates.				
10. In a social group, s/he can easily keep track of several different people's conversations.				
11. S/he finds social situations easy.				
12. S/he tends to notice details that others do not.				
13. S/he would rather go to a library than a party.				
14. S/he finds making up stories easy.				
15. S/he finds her/himself drawn more strongly to people than to things.				

	Definitely Agree	Slightly Agree	Slightly Disagree	Definitely Disagree
16. S/he tends to have very strong interests, which s/he gets upset about if s/he can't pursue.				
17. S/he enjoys social chit-chat.				
18. When s/he talks, it isn't always easy for others to get a word in edgeways.				
19. S/he is fascinated by numbers.				
20. When s/he is reading a story, s/he finds it difficult to work out the characters' intentions.				
21. S/he doesn't particularly enjoy reading fiction.				
22. S/he finds it hard to make new friends.				
23. S/he notices patterns in things all the time.				
24. S/he would rather go to the theatre than a museum.				
25. It does not upset him/her if his/her daily routine is disturbed.				
26. S/he frequently finds that s/he doesn't know how to keep a conversation going.				
27. S/he finds it easy to "read between the lines" when someone is talking to her/him.				
28. S/he usually concentrates more on the whole picture, rather than the small details.				
29. S/he is not very good at remembering phone numbers.				
30. S/he doesn't usually notice small changes in a situation, or a person's appearance.				
31. S/he knows how to tell if someone listening to him/her is getting bored.				

	Definitely Agree	Slightly Agree	Slightly Disagree	Definitely Disagree
32. S/he finds it easy to do more than one thing at once.				
33. When s/he talks on the phone, s/he is not sure when it's her/his turn to speak.				
34. S/he enjoys doing things spontaneously.				
35. S/he is often the last to understand the point of a joke.				
36. S/he finds it easy to work out what someone is thinking or feeling just by looking at their face.				
37. If there is an interruption, s/he can switch back to what s/he was doing very quickly.				
38. S/he is good at social chit-chat.				
39. People often tell her/him that s/he keeps going on and on about the same thing.				
40. When s/he was younger, s/he used to enjoy playing games involving pretending with other children.				
41. S/he likes to collect information about categories of things (e.g. types of car, types of bird, types of train, types of plant, etc.).				
42. S/he finds it difficult to imagine what it would be like to be someone else.				
43. S/he likes to plan any activities s/he participates in carefully.				
44. S/he enjoys social occasions.				
45. S/he finds it difficult to work out people's intentions.				
46. New situations make him/her anxious.				

	Definitely Agree	Slightly Agree	Slightly Disagree	Definitely Disagree
47. S/he enjoys meeting new people.				
48. S/he is a good diplomat.				
49. S/he is not very good at remembering people's date of birth.				
50. S/he finds it very to easy to play games with children that involve pretending.				

Scored: _____
Verified: _____
Entered: _____

Pre Post
Name: _____
Date: _____

SAS-A (Parent)
La Greca, 1998

Please answer each of the items regarding YOUR CHILD'S feelings and behavior. There are no right or wrong answers. Please answer as honestly as you can.

Use these numbers to show HOW MUCH each statement IS TRUE FOR YOUR CHILD:

1 = Not at all
2 = Hardly ever
3 = Sometimes
4 = Most of the time
5 = All the time

1. **My child worries about doing something new in front of others.**

1	2	3	4	5
Not at all	Hardly ever	Sometimes	Most of the time	All of the time

2. **My child likes to do things with his/her friends.**

1	2	3	4	5
Not at all	Hardly ever	Sometimes	Most of the time	All of the time

3. **My child worries about being teased.**

1	2	3	4	5
Not at all	Hardly ever	Sometimes	Most of the time	All of the time

4. **My child feels shy around people he/she doesn't know.**

1	2	3	4	5
Not at all	Hardly ever	Sometimes	Most of the time	All of the time

5. **My child only talks to people he/she knows really well.**

1	2	3	4	5
Not at all	Hardly ever	Sometimes	Most of the time	All of the time

6. **My child feels that peers talk behind his/her back.**

1	2	3	4	5
Not at all	Hardly ever	Sometimes	Most of the time	All of the time

7. **My child likes to read.**

1	2	3	4	5
Not at all	Hardly ever	Sometimes	Most of the time	All of the time

8. **My child worries about what others think of him/her.**

1	2	3	4	5
Not at all	Hardly ever	Sometimes	Most of the time	All of the time

9. **My child is afraid that others will not like him/her.**

1	2	3	4	5
Not at all	Hardly ever	Sometimes	Most of the time	All of the time

10. **My child gets nervous when talking to peers he/she doesn't know very well.**

1	2	3	4	5
Not at all	Hardly ever	Sometimes	Most of the time	All of the time

11. My child likes to play sports.

1	2	3	4	5
Not at all	Hardly ever	Sometimes	Most of the time	All of the time

12. My child worries about what others say about him/her.

1	2	3	4	5
Not at all	Hardly ever	Sometimes	Most of the time	All of the time

13. My child gets nervous when meeting new people.

1	2	3	4	5
Not at all	Hardly ever	Sometimes	Most of the time	All of the time

14. My child worries that others don't like him/her.

1	2	3	4	5
Not at all	Hardly ever	Sometimes	Most of the time	All of the time

15. My child is quiet when he/she is with a group of peers.

1	2	3	4	5
Not at all	Hardly ever	Sometimes	Most of the time	All of the time

16. My child likes to do things by him/herself.

1	2	3	4	5
Not at all	Hardly ever	Sometimes	Most of the time	All of the time

17. My child feels that others make fun of him/her.

1	2	3	4	5
Not at all	Hardly ever	Sometimes	Most of the time	All of the time

18. If my child gets into an argument with another person, my child worries that the other person will not like him/her.

1	2	3	4	5
Not at all	Hardly ever	Sometimes	Most of the time	All of the time

19. My child is afraid to invite others to do things with him/her because they might say no.

1	2	3	4	5
Not at all	Hardly ever	Sometimes	Most of the time	All of the time

20. My child feels nervous around certain peers.

1	2	3	4	5
Not at all	Hardly ever	Sometimes	Most of the time	All of the time

21. My child feels shy even with peers he/she knows well.

1	2	3	4	5
Not at all	Hardly ever	Sometimes	Most of the time	All of the time

22. It's hard for my child to ask others to do things with him/her.

1	2	3	4	5
Not at all	Hardly ever	Sometimes	Most of the time	All of the time