



# Shodair Children's Hospital

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## FAS/FAE PERSONAL BEHAVIORS AND SYMPTOMS

Patient's Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_

Name of Person Providing Patient Information: \_\_\_\_\_

How long have you known the patient? \_\_\_\_\_

What is your relationship to the patient? \_\_\_\_\_

Which of the following characteristics would you use to describe the person being evaluated as having? (Check all that apply.)

- |  |  |
|--|--|
| <input type="checkbox"/> Hyperactive   | <input type="checkbox"/> A risk-taker  |
| <input type="checkbox"/> Likes to talk; is chatty but with little content  | <input type="checkbox"/> Overly friendly with strangers  |
| <input type="checkbox"/> Inappropriate sexual behavior   | <input type="checkbox"/> Feeding problems (such as poor sucking as a baby, seemed to choke more than other children) |
| <input type="checkbox"/> Learning problems   | <input type="checkbox"/> Touches things and people frequently  |
| <input type="checkbox"/> Gets overstimulated, especially in a crowded room or when strangers are present         | <input type="checkbox"/> Fearless  |
| <input type="checkbox"/> Impulsive   | <input type="checkbox"/> Depressed/Poor self-esteem  |
| <input type="checkbox"/> Rapid mood swings   | <input type="checkbox"/> Poor judgment in the person he/she trusts   |
| <input type="checkbox"/> Poor attention span   | <input type="checkbox"/> Problems with personal hygiene  |
| <input type="checkbox"/> Has difficulty performing precise tasks with hands (like gluing models, using a pencil) | <input type="checkbox"/> Has trouble completing tasks  |

- |   |  |
|---|--|
| <input type="checkbox"/> Can't do three consecutive tasks   | <input type="checkbox"/> Hearing/visual problems   |
| <input type="checkbox"/> Can't understand subtle messages; needs strong, clear commands, often repeated                     | <input type="checkbox"/> Seems unaware of good manners   |
| <input type="checkbox"/> Is easily led by others  | <input type="checkbox"/> Has no close friends  |
| <input type="checkbox"/> Appears brighter than tests show/ gives the impression of being more capable than he/she really is | <input type="checkbox"/> Doesn't remember lessons previously taught and apparently learned         |
| <input type="checkbox"/> Sleeping problems  | <input type="checkbox"/> Very sensitive to loud noise  |
| <input type="checkbox"/> Unaware of consequences  | <input type="checkbox"/> Tries hard and wants to please, but the end result is often disappointing |
| <input type="checkbox"/> Has difficulty with new motor skills (like riding a bike)  | <input type="checkbox"/> Can't generalize from one situation to a similar one                      |

**Has this person ever:**

Had difficulty with toilet training, wetting the bed, or soiling self?

YES  NO  UNKNOWN

Had a problem stealing?

YES  NO  UNKNOWN

Had a problem with drug/alcohol abuse?

YES  NO  UNKNOWN

Been involved with the law?

YES  NO  UNKNOWN

Been seen for mental health counseling?

YES  NO  UNKNOWN

Been in Special Education classes?

YES  NO  UNKNOWN

Had difficulty holding a job?

YES  NO  UNKNOWN

Had medications prescribed (for example: Ritalin, antidepressants) to control his/her behavior?

YES  NO  UNKNOWN

Please list the medications that he/she is currently taking: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please explain/list any specific problems this person has in school: \_\_\_\_\_

\_\_\_\_\_

What is the area or areas in which this person does his/her best (such as music, art, or sports)? \_\_\_\_\_

\_\_\_\_\_

Please list the things you have discovered that you can do to help this person. Are there any special needs of this individual? \_\_\_\_\_

\_\_\_\_\_

What are the main problems that you see concerning this patient? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list any special concerns that you have. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list the **dates** and/or **ages** that this patient was living in each of these different situations. (Please list **every** placement).

Biological parents: \_\_\_\_\_

Extended family members: \_\_\_\_\_

\_\_\_\_\_

Foster parents: \_\_\_\_\_

\_\_\_\_\_

Adoptive parents: \_\_\_\_\_

\_\_\_\_\_

Other: \_\_\_\_\_

\_\_\_\_\_

**Thank you very much for your time and effort in providing honest comments.  
Your answers to these questions will help us with our assessment.**