Childs Name: Date of birth:

(Ages 27-32 months)

INSTRUCTIONS				
1. Please circle the box that best describes your child's behavior. **2. Please circle "Concerned", if this behavior is a concern.**				
1. Does your child look at you when you talk to him/her?	Yes	No	Sometimes	Concerned
2. Does your child like to be hugged or cuddled?	Yes	No	Sometimes	Concerned
3. Does your child cling to you more than you expect?	Yes	No	Sometimes	Concerned
4. Does your child greet or say hello to familiar adults?	Yes	No	Sometimes	Concerned
5. Does your child seem happy?	Yes	No	Sometimes	Concerned
6. Does your child like to hear stories and sing songs?	Yes	No	Sometimes	Concerned
7. Does your child seem too friendly with strangers?	Yes	No	Sometimes	Concerned
8. Does your child seem more active than other children his/her age?	Yes	No	Sometimes	Concerned
9. Can your child settle himself down after periods of exciting activity?	Yes	No	Sometimes	Concerned
10. Does your child cry, scream, or have tantrums for long periods of time?	Yes	No	Sometimes	Concerned
11. Does your child do things over and over and can't seem to stop? Examples are rocking, hand flapping, spinning, or _____ (You may write in something else.)	Yes	No	Sometimes	Concerned
12. Can your child stay with activities he/she enjoys for at least 3 minutes (not including watching television)?	Yes	No	Sometimes	Concerned
13. Does your child do what you ask him/her to do?	Yes	No	Sometimes	Concerned
14. Is your child interested in things round him/her, such as people, toys, and foods?	Yes	No	Sometimes	Concerned
15. When upset, can your child calm down within 15 minutes?	Yes	No	Sometimes	Concerned
16. Does your child have eating problems, such as stuffing foods, vomiting, eating nonfood items, or _____? (You may write in another problem.)	Yes	No	Sometimes	Concerned
17. Do you and your child enjoy mealtimes together?	Yes	No	Sometimes	Concerned
18. When you point at something, does your child look in the direction you are pointing?	Yes	No	Sometimes	Concerned
19. Does your child sleep at least 8 hours in a 24-hour period?	Yes	No	Sometimes	Concerned
20. Does your child let you know how he/she is feeling with either words or gestures? For example, does he/she let you know when he/she is hungry, hurt, or tired?	Yes	No	Sometimes	Concerned
21. Does your child follow routine directions? For example, does he/she come to the table or help clean up his/her toys when asked?	Yes	No	Sometimes	Concerned
22. Does your child check to make sure you are near when exploring new places, such as a park or a friend's home?	Yes	No	Sometimes	Concerned
23. Can your child move from one activity to the next with little difficulty, such as from playtime to mealtime?	Yes	No	Sometimes	Concerned
24. Does your child stay away from dangerous things, such as fire and moving cars?	Yes	No	Sometimes	Concerned
25. Does your child destroy or damage things on purpose?	Yes	No	Sometimes	Concerned
26. Does your child hurt himself on purpose?	Yes	No	Sometimes	Concerned
27. Does your child play alongside other children?	Yes	No	Sometimes	Concerned
28. Does your child try to hurt other children, adults, or animals (for example, by kicking or biting)?	Yes	No	Sometimes	Concerned