The Advocacy Network on Disabilities

Formerly known as CCDH, Inc.

YEN "Getting to Know Me"

Name: _____

D.O.B. _____ Date_____

Please tell us about yourself. This form will not be shared with others, please answer it truthfully. Letting us know your strengths and challenges helps us to better assist you.

1. Which best describes you? (check all that apply)

❑ I would rather read instructions than listen to the teacher explain them.
❑ I like having someone explain directions aloud.
❑ When I study, I have to take a lot of breaks to get up and walk around.
❑ I draw a lot of pictures during class.
❑ I remember things better if I write them down.
❑ I study by saying information aloud.
❑ Charts, pictures, and maps help me understand what I am reading.
❑ I can pay attention better if I have a snack while I study.
❑ I like to listen to music while I am studying.
❑ I am good at seeing pictures in my mind what I am studying.
❑ It is easy for me to remember jokes.
❑ I can think better if I tap my foot, play with a pencil or move a little.
❑ I prefer working by myself.
❑ I prefer working with a friend.
❑ I prefer working in a group of 3 or more.
❑ I find it easy to speak up in class and/or participate in discussions.
❑ I find it hard to speak up in class and/or participate in discussions.
❑ I find it easy to read aloud.
❑ I find it hard to read aloud.
❑ I find it easy to control my temper.
❑ I find it hard to control my temper.
❑ It is easier for me to control my temper if I try the following:

_____

_____

2. Have you received or are you receiving any of the following? (check all that apply)

❑ Speech/Language therapy
❑ Occupational Therapy
❑ Physical Therapy
❑ Daily Medication (not including vitamins)
❑ Special Education services in school
❑ Counseling
❑ Other:_____

3. I learn best when I:

_____

_____

4. I do not like it when I am asked to:

_____

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5. Activities/things that motivate me:

6. Activities I do not like to do:

7. School subjects I am good at:

8. School subjects I find hard:

9. After high school, I want to:

10. Anything else you want us to know about you:

The Advocacy Network on Disabilities

"Getting to Know Me"

Child's Name _____

D.O.B. _____ Date _____

We want to get to know your child better so that we can provide the best possible educational experience. No one knows your child better than you. Tell us more about your child.

1. We want to know about your child's favorite/least favorite toys/activities/rewards:

Favorite	Least favorite
_____	_____
_____	_____
_____	_____

2. What calms your child and what upsets your child?

Calms	Upsets
_____	_____
_____	_____
_____	_____

3. How does your child communicate?

- ❑ Verbally
- ❑ With vocalizations
- ❑ Through gestures (i.e., pointing, pulling, blinking)
- ❑ With communication devices (i.e., pictures)
- ❑ American Sign Language (ASL)
- ❑ Other (please specify) _____

4. What services does your child receive?

- ❑ Speech/Language Therapy
- ❑ Behavioral
- ❑ Physical Therapy
- ❑ Mental Health Counseling
- ❑ Occupational Therapy
- ❑ None

May we contact your service provider to better support your child? ❑ Yes ❑ No (Signed authorization form required)

5. Does your child require assistive devices or equipment? (i.e., braces, walker, wheelchair, communication device, insulin, nebulizer)

❑ Yes ❑ No If yes, please describe _____

6. Do you suspect your child has a hearing or vision problem? ❑ Yes ❑ No

If yes, please describe _____

7. Which statement best describes your child's ability to move from one activity to another?

- ❑ Easily moves from one activity to the other
- ❑ Needs assistance to move from one activity to the other

Please explain _____

8. Does your child play/interact best (please check all that apply):

- ❑ Independently
- ❑ With another child
- ❑ Small group
- ❑ Large group
- ❑ Outdoor
- ❑ Indoor
- ❑ With adults
- ❑ Additional comments: _____

The Children's Trust

The Advocacy Network on Disabilities

"Getting to Know Me"

Child's Name _____

D.O.B. _____ Date _____

9. **Do any of the following bother your child?**

❑ Noise ❑ Texture (i.e., sand, water) ❑ Lights ❑ Touch (i.e., hugs)

❑ Smells ❑ Other _____

10. **Does your child wander, run away or bolt?** ❑ Yes ❑ No

If yes, what situations precede this behavior? _____

11. **Is your child able to do the following activities by him/herself?**

Use the toilet ❑ Yes ❑ No Walk/move about ❑ Yes ❑ No

Eat ❑ Yes ❑ No Wash his/her hands ❑ Yes ❑ No

If no, please describe what assistance is needed: _____

12. **Does your child take medication?** ❑ Yes ❑ No

Medication side effects staff should be aware of: _____

Is there anything else you would like to share about your child (i.e., allergies, diet, seizures, nosebleeds)?

_____

_____

_____

_____

The Children's Trust