

**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)

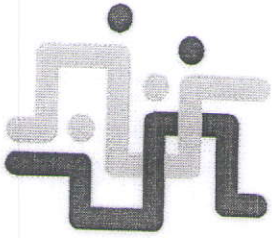
- | | |
|--|--|
| <input type="checkbox"/> I would rather read instructions than listen to the teacher explain them. | <input type="checkbox"/> I can think better if I tap my foot, play with a pencil or move a little. |
| <input type="checkbox"/> I like having someone explain directions aloud. | <input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

- | | |
|--|---|
| <input type="checkbox"/> Speech/Language therapy | <input type="checkbox"/> Special Education services in school |
| <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Counseling |
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Daily Medication (not including vitamins) | |

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:

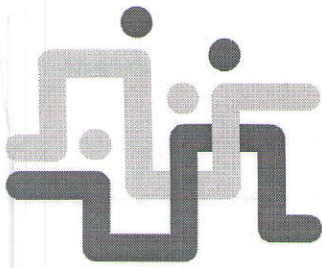
6. Activities I do not like to do:

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 Through gestures (i.e., pointing, pulling, blinking) American Sign Language (ASL)
 With vocalizations With communication devices (i.e., pictures)
 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 _____

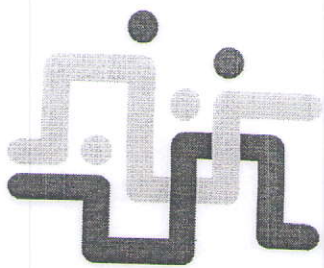
7. Which statement best describes your child's ability to move from one activity to another?

- 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: _____



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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 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Walk/move about | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Eat | <input type="checkbox"/> Yes <input type="checkbox"/> No | Wash his/her hands | <input type="checkbox"/> Yes <input type="checkbox"/> 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)?

