



# Patient Evaluation Form

# Patient's details

- ASD     ADHD     DEVELOPMENT DELAY     INTELLECTUAL DISORDER  
 CP     DEPRESSION     ANXIETY     GENETIC DISORDER     DOWN SYNDROME

\*ASD-Autism spectrum disorder ADHD -Attention-deficit / hyperactivity disorder CP -Cerebral palsy

Patient name ..... Date of birth :.....

Birth Place (Nearest town/city).....Birth time.....AM  .....PM

Birth Type                     Natural                     Cesarean                     Suction

Gender :                     Male                     Female

Age :                     Years

Parent : (Father and Mother)     Close relative                     Distant relative                     Not connected

Parent name .....

Address .....

.....

.....

Contact no :.....

Mail id :.....

Referred by :.....

- Present training undergoing:     Speech therapy                     Animal therapy                     Behavioural therapy
- Occupational therapy     Play therapy                     Sensory integration therapy
- Remedial education

Medicines consuming ( if any ): .....

.....

Duration:.....                    Details.....

.....

Parent's Signature
Name
Date

**Note:** Mark tick in the relevant questions applicable to you.

SL.no.	Question Nos	Question	Observations <input checked="" type="checkbox"/>	
<b>1. POOR EYE CONTACT</b>				
1	1.1	Inattention	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2	1.2	Looking sideways / top upwards and downwards	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3	1.3	No facial expressions / lack of shyness	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4	1.4	Gazing for too long on one spot	Yes <input type="checkbox"/>	No <input type="checkbox"/>
5	1.5	Dislike to have eye contact during conversations	Yes <input type="checkbox"/>	No <input type="checkbox"/>
6	1.6	Uninterested in observing things	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>2. ABNORMAL FACIAL FEATURES</b>				
7	2.1	An asymmetrical face shape	Yes <input type="checkbox"/>	No <input type="checkbox"/>
8	2.2	Small size of head compared to normal children at birth and during growth.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
9	2.3	Elderly face appears during birth or within few days of birth.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
10	2.4	Tongue sticking out.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
11	2.5	Uncontrolled saliva dripping out of mouth	Yes <input type="checkbox"/>	No <input type="checkbox"/>
12	2.6	Tufts of hair growing in the wrong direction	Yes <input type="checkbox"/>	No <input type="checkbox"/>
13	2.7	Hair density is less compared to normal children.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
14	2.8	Teeth growth is slower than normal children	Yes <input type="checkbox"/>	No <input type="checkbox"/>
15	2.9	Eye position, small size, angle of eye position and focus of eye looks like Lord Ganesh	Yes <input type="checkbox"/>	No <input type="checkbox"/>
16	2.10	Issues with retinal nervous system of eye when check by ophthalmologist.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
17	2.11	A prominent forehead (frontal bossing) and wide set eyes	Yes <input type="checkbox"/>	No <input type="checkbox"/>
18	2.12	Expressionless face and thin upper lips	Yes <input type="checkbox"/>	No <input type="checkbox"/>
19	2.13	Opened mouth appearance	Yes <input type="checkbox"/>	No <input type="checkbox"/>
20	2.14	Prominent ears (ears that stick out more than 2 cm from the side of the head) / abnormal growth of the ears.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>3. ABNORMAL BODY POSTURE/FEATURES</b>				
21	3.1	Fatigue	Yes <input type="checkbox"/>	No <input type="checkbox"/>
22	3.2	Toe walking	Yes <input type="checkbox"/>	No <input type="checkbox"/>
23	3.3	Instability of their foot, ankle and hip joints	Yes <input type="checkbox"/>	No <input type="checkbox"/>
24	3.4	Disrupted and collapsed foot structure	Yes <input type="checkbox"/>	No <input type="checkbox"/>
25	3.5	Abnormal, weird sleeping posture	Yes <input type="checkbox"/>	No <input type="checkbox"/>
26	3.6	Hand palm print are sticking together	Yes <input type="checkbox"/>	No <input type="checkbox"/>
27	3.7	Instability of neck and head	Yes <input type="checkbox"/>	No <input type="checkbox"/>
28	3.8	The gap between toes are larger than normal children	Yes <input type="checkbox"/>	No <input type="checkbox"/>
29	3.9	Have shorter fingers in hand and shorter toes in foot	Yes <input type="checkbox"/>	No <input type="checkbox"/>
30	3.10	Poor, improper nail growth and brittle nails	Yes <input type="checkbox"/>	No <input type="checkbox"/>
31	3.11	Muscle density, stiffness toning of muscle is low / poor compared to normal children.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
32	3.12	W-sitting position	Yes <input type="checkbox"/>	No <input type="checkbox"/>

**Note:** Mark tick in the relevant questions applicable to you.

SL.no.	Question Nos	Question	Observations <input checked="" type="checkbox"/>	
<b>4. MANNERISMS OF THEIR HANDS</b>				
33	4.1	Flapping their hands to move up and down or from side to side	Yes <input type="checkbox"/>	No <input type="checkbox"/>
34	4.2	Finger twisting	Yes <input type="checkbox"/>	No <input type="checkbox"/>
35	4.3	Flicking (to make something move with a sudden movement)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
36	4.4	Rubbing their hands	Yes <input type="checkbox"/>	No <input type="checkbox"/>
37	4.5	Hand stretching / wrist twisting often	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>5. MANNERISM OF THE BODY</b>				
38	5.1	Rocking their body	Yes <input type="checkbox"/>	No <input type="checkbox"/>
39	5.2	Swaying their body (move back and front)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
40	5.3	Pacing (walking up and down repeatedly)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
41	5.4	Spining objects (to turn or to make something turn around quickly)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
42	5.5	Sitting legs crossed on chair	Yes <input type="checkbox"/>	No <input type="checkbox"/>
43	5.6	Their hips are very flexible	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>6. ABNORMAL TONE</b>				
44	6.1	Flat and toneless voice	Yes <input type="checkbox"/>	No <input type="checkbox"/>
45	6.2	Exaggerated and hyper voice	Yes <input type="checkbox"/>	No <input type="checkbox"/>
46	6.3	Inadaptability voice according to environment	Yes <input type="checkbox"/>	No <input type="checkbox"/>
47	6.4	Repetition of words or sentences	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>7. THOUGHT PROCESS</b>				
48	7.1	Constantly thinking, day dreaming or visualizing and living with big dreams and unrealistic ideas	Yes <input type="checkbox"/>	No <input type="checkbox"/>
49	7.2	Absent minded behaviors	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>8. BEHAVIORAL DISTURBANCES</b>				
50	8.1	Behavior/not adoptable / very punctual in timing / rigid activities	Yes <input type="checkbox"/>	No <input type="checkbox"/>
51	8.2	Repetitive body movements	Yes <input type="checkbox"/>	No <input type="checkbox"/>
52	8.3	Attachments to unusual objects (keys, light switches, string, stick, toy, bottle)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
53	8.4	Aggressive behaviors (irritability, easily upset, easily offended, state of being agitated)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
54	8.5	Failure or refuse to follow the instructions	Yes <input type="checkbox"/>	No <input type="checkbox"/>
55	8.6	Difficulty with grooming behaviors (appearance clean and neat, getting dresses, safe food handling, following school rules, removal of panties)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
56	8.7	Moves around in the classroom during class timings	Yes <input type="checkbox"/>	No <input type="checkbox"/>
57	8.8	Non-stop talking , interrupts other's conversations	Yes <input type="checkbox"/>	No <input type="checkbox"/>
58	8.9	Imaginary talks	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>9. DEFICTS IN LANGUAGE COMPREHENSION</b>				
59	9.1	Difficulty in understanding what is said to them	Yes <input type="checkbox"/>	No <input type="checkbox"/>
60	9.2	Difficulty in pronouncing the words	Yes <input type="checkbox"/>	No <input type="checkbox"/>
61	9.3	Difficulty in understanding dialogue of characters of movie or radio commentary	Yes <input type="checkbox"/>	No <input type="checkbox"/>

**Note:** Mark tick in the relevant questions applicable to you.

SL.no.	Question Nos	Question	Observations	<input checked="" type="checkbox"/>
<b>10. RECEPTIVE DISORDER HAS TROUBLE IN UNDESTANDING WORDS THAT THEY HEAR AND READ</b>				
62	10.1	Unable to understand what is read	Yes <input type="checkbox"/>	No <input type="checkbox"/>
63	10.2	Incapable to learn new words	Yes <input type="checkbox"/>	No <input type="checkbox"/>
64	10.3	Unable to answer the questions	Yes <input type="checkbox"/>	No <input type="checkbox"/>
65	10.4	Unable to following directions	Yes <input type="checkbox"/>	No <input type="checkbox"/>
66	10.5	Unable to identify objects	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>11. EXPRESSIVE DISORDER HAS TROUBLE IN SPEAKING WITH OTHERS AND EXPRESSING THOUGHTS AND FEELINGS</b>				
67	11.1	Difficulty in using words correctly	Yes <input type="checkbox"/>	No <input type="checkbox"/>
68	11.2	Difficulty in expressing thoughts and ideas	Yes <input type="checkbox"/>	No <input type="checkbox"/>
69	11.3	Unable to tell stories	Yes <input type="checkbox"/>	No <input type="checkbox"/>
70	11.4	Unable to show gestures	Yes <input type="checkbox"/>	No <input type="checkbox"/>
71	11.5	Difficulty in asking questions	Yes <input type="checkbox"/>	No <input type="checkbox"/>
72	11.6	Unable to sing a song or recit a poem	Yes <input type="checkbox"/>	No <input type="checkbox"/>
73	11.7	Capable of showing gestures only	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>12. DELAY IN SPEECH</b>				
74	12.1	Limited communication function	Yes <input type="checkbox"/>	No <input type="checkbox"/>
75	12.2	They babble(babbling) to engage another person's attention	Yes <input type="checkbox"/>	No <input type="checkbox"/>
76	12.3	Poor grammatical structures	Yes <input type="checkbox"/>	No <input type="checkbox"/>
77	12.4	Irregular intonation and articulation	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>13. INAPPROPRIATE SOCIAL INTERACTION</b>				
78	13.1	They do not like being hugged or kissed.They will push others when they come near them to hug or kiss or place their hands in the place where, people try to kiss.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
79	13.2	Expressing inappropriate emotions (laughing or smiling at the wrong time and place)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
80	13.3	Repetitive conversational topic when they meet others	Yes <input type="checkbox"/>	No <input type="checkbox"/>
81	13.4	They have a desire to interact with others, but they do not know how to engage friends	Yes <input type="checkbox"/>	No <input type="checkbox"/>
82	13.5	They cannot tolerate other children	Yes <input type="checkbox"/>	No <input type="checkbox"/>
83	13.6	They do not wait for their turn	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>14. INTENSE FOCUS ON ONE TOPIC</b>				
84	14.1	Restricted and repetitive interest and activities	Yes <input type="checkbox"/>	No <input type="checkbox"/>
85	14.2	Opening and closing of the doors / gates	Yes <input type="checkbox"/>	No <input type="checkbox"/>
86	14.3	They focus on some things ignoring others	Yes <input type="checkbox"/>	No <input type="checkbox"/>
87	14.4	Looks straight past objects and people (visual disturbances)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>15. LACK OF EMPATHY AND SYMPATHY</b>				
88	15.1	They withdraw from crowds since they feel confused to understand others emotions	Yes <input type="checkbox"/>	No <input type="checkbox"/>
89	15.2	Shows poor response or urge to help when others are hurt, in pain or distress. ( lack of empathy & sympathy)	Yes <input type="checkbox"/>	No <input type="checkbox"/>

**Note:** Mark tick in the relevant questions applicable to you.

SL.no.	Question Nos	Question	Observations <input checked="" type="checkbox"/>	
<b>16. LACK OF UNDERSTANDING SOCIAL CUES</b>				
90	16.1	Impulsivity behavior (acting without thinking first)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
91	16.2	Calling out in class	Yes <input type="checkbox"/>	No <input type="checkbox"/>
92	16.3	Interrupts conversations / games	Yes <input type="checkbox"/>	No <input type="checkbox"/>
93	16.4	Engaging in dangerous activities without considering possible consequences	Yes <input type="checkbox"/>	No <input type="checkbox"/>
94	16.5	Blurting out answers before question have been complete	Yes <input type="checkbox"/>	No <input type="checkbox"/>
95	16.6	Difficulty in listening and speaking	Yes <input type="checkbox"/>	No <input type="checkbox"/>
96	16.7	Difficulty in reading, writing and solving problems	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>17. NON INVOLVEMENT TO PLAY WITH PEERS (their equals)</b>				
97	17.1	Child socialize only with adults	Yes <input type="checkbox"/>	No <input type="checkbox"/>
98	17.2	Incapable to play with peers	Yes <input type="checkbox"/>	No <input type="checkbox"/>
99	17.3	They do not identify adults or kids	Yes <input type="checkbox"/>	No <input type="checkbox"/>
100	17.4	Unable to identify gender	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>18. SHOWS EXAGGERATED EMOTIONS</b>				
101	18.1	Fear of rain, thunder etc.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
102	18.2	Extreme fear which leads to uncontrolled behavior	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>19. LACKS FEAR OF DANGER</b>				
103	19.1	They may not show sign of fear for dangerous environment	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>20. SELF ABUSIVE BEHAVIORS (SELF INJURY BEHAVIOR)</b>				
104	20.1	Head banging on floors, wall or against other objects	Yes <input type="checkbox"/>	No <input type="checkbox"/>
105	20.2	Hand or arms biting, hair pulling, eye gonging (act of pressing or teasing one's eyes) face or head slapping , chin hitting, scratching face or arms, hitting, kicking, pinching etc.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
106	20.3	Engages in wrist-biting ( due to frustration) and excessive self-scratching (due to self stimulation)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
107	20.4	Eye poking behavior	Yes <input type="checkbox"/>	No <input type="checkbox"/>
108	20.5	uncontrolable self-injury behaviors.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
109	20.6	Hits other when they are aggressive	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>21. SLEEP DISTURBANCES</b>				
110	21.1	Many wake up frequently during the night	Yes <input type="checkbox"/>	No <input type="checkbox"/>
111	21.2	Lying awake untill very late or waking early in the morning	Yes <input type="checkbox"/>	No <input type="checkbox"/>
112	21.3	Bed wetting	Yes <input type="checkbox"/>	No <input type="checkbox"/>
113	21.4	Bad toilet habits	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>22. REMAINS ALOOF</b>				
114	22.1	Remains aloof and not responsive to people or environment	Yes <input type="checkbox"/>	No <input type="checkbox"/>
115	22.2	They do not responds to their name, and even if they do, it may not be appropriate	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>23. DIFFICULTY IN USING SIGNS OR GESTURES TO COMMUNICATE</b>				
116	23.1	They find it difficult to express their needs non-verbally and may also have dificulty in understanding the non-verbal language of others.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
117	23.2	Instead of gesturing or pointing, they may lead others to desired object by dragging or pulling the latter's hand	Yes <input type="checkbox"/>	No <input type="checkbox"/>

**Note:** Mark tick in the relevant questions applicable to you.

SL.no.	Question Nos	Question	Observations	<input checked="" type="checkbox"/>
<b>24. SIMPLICITY IN USING SIGNS OR GESTURES TO COMMUNICATE</b>				
118	24.1	They use only signs or gestures to communicate	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>25. ABSENCE OF SOCIAL SMILE</b>				
119	25.1	They do not smile when meeting people	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>26. PRODUCES INFANTILE SQUEALS/UNUSUAL NOISES</b>				
120	26.1	The child may squeal, make bizarre noises and produce unrecognizable speeches like sounds or words which conveys no meaning	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>27. USES PRONOUN REVERSALS</b>				
121	27.1	They may show difficulty in the use of pronouns	Yes <input type="checkbox"/>	No <input type="checkbox"/>
122	27.2	They frequently reverse pronouns such as "I" for "You" etc.,	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>28. UNABLE TO GRASP THE REAL MEANING OF COMMUNICATION</b>				
123	28.1	They have difficulty in understanding the true intent of speech of others	Yes <input type="checkbox"/>	No <input type="checkbox"/>
124	28.2	when somebody asks them "can you tell the time? They may say "yes" and stop	Yes <input type="checkbox"/>	No <input type="checkbox"/>
125	28.3	Has difficulty to understand humour and sarcasm in movie scenes and real life	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>29. SHOWS HYPERACTIVITY / RESTLESSNESS</b>				
126	29.1	They may be restless with boundless energy which makes it difficult for others to control them	Yes <input type="checkbox"/>	No <input type="checkbox"/>
127	29.2	Loves Jumping, heights and spinning.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>30. THROWS TEMPER OUTBURST</b>				
128	30.1	They may show temper tantrums in the form of head banging, screaming and yelling etc	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>31. RIGID ACTIVITIES</b>				
129	31.1	Any change in the schedule leads to frustration and temper tantrums	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>32. ABNORMAL SENSITIVE TO SENSORY ORGANS</b>				
130	32.1	They may act strongly to certain sounds, light, touch or tastes by closing their ears and eyes.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
131	32.2	They are very selective in their food habits	Yes <input type="checkbox"/>	No <input type="checkbox"/>
132	32.3	Acts strongly to certain lights	Yes <input type="checkbox"/>	No <input type="checkbox"/>
133	32.4	Acts strongly to darkness	Yes <input type="checkbox"/>	No <input type="checkbox"/>
134	32.5	Negative reaction to touch	Yes <input type="checkbox"/>	No <input type="checkbox"/>
135	32.6	Cannot sit still	Yes <input type="checkbox"/>	No <input type="checkbox"/>
136	32.7	Can Spin continuously without getting dizzy	Yes <input type="checkbox"/>	No <input type="checkbox"/>
137	32.8	Under sensitivity-getting nervous or restless	Yes <input type="checkbox"/>	No <input type="checkbox"/>
138	32.9	Visual stimulation-don't pick up social clues	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>33. DIFFICULTY IN TRACKING OBJECTS</b>				
139	33.1	They may have difficulty in tracking objects or person in motion	Yes <input type="checkbox"/>	No <input type="checkbox"/>
140	33.2	Will find it difficult to catch a ball or to throw a ball precisely	Yes <input type="checkbox"/>	No <input type="checkbox"/>

**Note:** Mark tick in the relevant questions applicable to you.

SL.no.	Question Nos	Question	Observations <input checked="" type="checkbox"/>	
<b>34. UNUSUAL VISIONS</b>				
141	34.1	The child is looking at some miniscule part of the object or toy from the corners of his eyes or bring objects very close to the eyes and stares.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
142	34.2	Searching even if an object is in front could not locate it easily or find.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>35. INSENSITIVE TO PAIN</b>				
143	35.1	Persons with autism may hardly react to non bleeding pain when getting injured	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>36. RESPOND TO OBJECTS BY SMELLING, TOUCHING OR TASTING</b>				
144	36.1	They may go around exploring their environment by smelling, touching or tasting objects	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>37. UNSTABLE IN CONCENTRATION</b>				
145	37.1	They do not concentrate	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>38. SHOWS DELAY IN RESPONDING</b>				
146	38.1	They do not respond to instructions promptly or respond after a considerable delay	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>39. HAS UNUSUAL MEMORY</b>				
147	39.1	Do they have good memory	Yes <input type="checkbox"/>	No <input type="checkbox"/>
148	39.2	Is the child capable of recognizing persons	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>40. HAS SAVANT ABILITY (EXTRAORDINARY SKILLS)</b>				
149	40.1	Do they have any extraordinary ability	Yes <input type="checkbox"/>	No <input type="checkbox"/>

**Remarks:** (Write your comments).....  
 .....  
 .....  
 .....  
 .....  
 .....

Parent's Signature

Name

Date





**NANO  
MEDICARE**

**FOR INNER  
ENGINEERING**



**Manushyaa Blossom Multi Speciality Siddha Clinic**

Manushyaa Blossom Private Limited

- 📍 No. 5 (old No. 20), E - Block, 2nd Street Anna Nagar East,  
Chennai - 600 102 Tamilnadu, India
- ☎ +91 44 26210606
- 📞 +91 8939 722 033
- ✉ info@manushyaablossom.com
- 🌐 www.manushyaablossom.com