

Student Intake Information Form

General Information

Student Information

Today's Date: _____

- Student's Name: _____ Gender: _____ Age: _____ DOB: _____
- Home Address: _____ City: _____
- Zip Code: _____ Home phone: () _____
- Application completed by: _____ e-mail address: _____
- Please describe the nature of this student's difficulties: _____

- School presently attending: _____ Current grade: _____
- Phone: () _____ Date started: _____ Teacher: _____

→ I have received and agree with the informed consent: No Yes

Referral Information

- Referred by: _____ Phone number: () _____
- Address: _____ City: _____ Zip Code: _____

Parent Information

- **Mother:** Name: _____ Home phone: () _____
- Address (if different from above): _____
- City: _____ State: _____ Zip code: _____
- Employer: _____ Cell phone: () _____
- SSN: _____ Mother's Date of Birth: _____

- **Father:** Name: _____ Home phone: () _____
- Address (if different from above): _____
- City: _____ State: _____ Zip code: _____
- Employer: _____ Cell phone: () _____
- SSN: _____ Father's Date of Birth: _____

- **Step-Parent:** Name: _____ Home phone: () _____
- Employer: _____ Cell phone: () _____
- SSN: _____ Date of Birth: _____

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- **Step-Parent:** Name: _____ Home phone: () _____
 - Employer: _____ Cell phone: () _____
 - SSN: _____ Date of Birth: _____

Psychosocial History

Parents

- Education level of Mother: _____ Occupation: _____
- Mother's ethnicity:
 - Caucasian African American Hispanic Asian/Asian American
 - Native American Other: _____
- What culture does Mother identify with? _____
- Mother's religious affiliation: _____
- Level of spirituality: _____

- Education level of Father: _____ Occupation: _____
- Father's ethnicity:
 - Caucasian African American Hispanic Asian/Asian American
 - Native American Other: _____
- What culture do you identify with? _____
- Father's religious affiliation: _____
- Level of spirituality: _____

Annual Family Income: \$ _____

- If parents are separated or divorced: Date: _____ Student's age: _____
Student's reaction: _____
- What are the current legal custody arrangements? Joint legal Other, _____
- What is the current living and visitation arrangement? _____

→ **Please note, if parents are *divorced*, you must attach a copy of the legal custody agreement and both parents must sign an informed consent.**

- Is a parent deceased? No Yes If yes, please describe: _____
 - Was the student adopted ? No Yes If yes, student's age at adoption _____
 - Are there any family problems or recent changes that you feel might be contributing to this student's difficulties? No Yes If yes, please describe: _____
-

Siblings

- Please list all siblings (including step-siblings), current ages, and gender:

1. _____ 3. _____
 2. _____ 4. _____

Family Relationships

- Please describe this student's relationship with:

Mother: _____

Father: _____

Siblings: _____

Others: _____

- Please describe the parenting styles of each parent:

- At present, what behavior is the most difficult for you to handle? _____

- How do you and your spouse handle discipline issues? _____

- How much supervision does this student need?

More than peers About the same as peers Less than peers

Developmental History

Pregnancy

- Mother's overall health during pregnancy: _____

- Was mother exposed to any infectious diseases (e.g., rubella, syphilis, AIDS, toxoplasmosis) during the pregnancy? No Yes

- Medications used by mother during pregnancy:

None

Prescription medications,
Name: _____

Non-prescription medications,
Name: _____

Caffeine Tobacco Alcohol Other: _____

- Mother's diet during pregnancy: Good Average Poor
- Did mother take daily vitamins during her pregnancy? No Yes
- Medications used by father 6 months prior to pregnancy:

None

Prescription medications,
Name: _____

Non-prescription medications,
Name: _____

Caffeine Tobacco Alcohol Other: _____

- Father's diet prior to pregnancy: Good Average Poor
- Was the father's exposed to high amounts of teratogens such as radiation, lead, or pesticides prior to pregnancy? No Yes

Birth

- Mother's age at delivery: _____ Any labor or birth complications: _____

APGAR Scores (if known) : 1 min. _____ 5 mins. _____ 10 mins. _____

Premature, weeks early: _____ On Time Late, weeks late: _____

Evidence of fetal distress: _____

- Was the baby taken away following delivery? No Yes
- Was the baby allowed to nurse following delivery? No Yes
- Father's age at delivery: _____

Sensory Functioning

- Are you aware of any problems your child has processing sensory information (e.g., visual, auditory, touch, taste, smell)? If yes, please explain: _____

- Does your child have synesthesia? No Yes. Synesthesia is the involuntary stimulation of one sensory modality reliably causes a perception in one or more different senses? For example, letter/numbers may have colors (e.g., the letter "A" may be red), a person might describe the color, shape, and flavor of someone's voice, music has a shape to it, or a scent is associated with a color.

- Is your child “hypersensitive” to, or does it cause your child undue stress/anxiety, when s/he encounters: light touch sudden movement high frequency noises
 excessive noise excess of visual stimuli certain smells
 certain foods/tastes

Early Development

- Did the baby “nestle”? No Yes
 - Did the baby prefer separate space to being held? No Yes
 - Did the baby prefer to be tightly wrapped or “swaddled”? No Yes
 - Was the baby’s cry soothed when: ...fed? No Yes ...held? No Yes
...changed? No Yes...bathed? No Yes ...rocked? No Yes
 - Was the baby breast fed? No Yes
 - Were there *feeding problems*? If yes, please describe: _____
 - Did the baby sleep in a separate crib? No Yes
 - Was the crib in the same room with mother? No Yes
 - What was the *general temperament* of this student during the early years?
 Easy, adaptable Withdrawn, slow to adapt Difficult, intense reactions Colicky
 - Did the baby attach to the primary caretaker? No Yes
 - Who was the primary caretaker? _____
 - Would you consider the *early attachment* between mother and baby:
 Strong Moderate Weak
 - How would you describe this student’s early *sleeping patterns*?
 Regular and predictable Irregular and unpredictable
 Required very little sleep Required much sleep
 - How would you describe this student’s early *feeding patterns*?
 Regular and predictable Irregular and unpredictable
 Required little food Required much food
 - What was this student’s early *general activity level*?
 Hyperactive Active Average Low energy Lethargic
 - In general, was this student: Easy to care for Difficult to care for
 - How did this student respond to *changes in routine* or to *transitions*?
 Easy, adaptable Withdrawn, slow to adapt Difficult Crying/Screaming
 - Did *toilet training* present any difficulties? No Yes If yes, please describe: _____
-
- Was this student exposed to *physical abuse*? No Yes
 - Was this student exposed to *emotional abuse*? No Yes
 - Was this student exposed to *sexual abuse*? No Yes

- Was this student exposed to any traumatic events? No Yes, what: _____

- Please describe any other *significant events* during this student's early years (e.g., postpartum depression, illness, trauma, moves, marital difficulties) and their impact on this student:

- Age when you noticed that something was not quite right with you child? _____
- What were the first symptoms you noticed that concerned you?

- Has your child's functioning declined in any area? If yes, please describe:

Language Development

- During the first year of life, other than crying, would you say that this student was a:
 - Silent or very quiet baby
 - Very noisy baby
 - Verbally interactive baby
- How was this student's language development? Consistent With significant breaks
- First spoken words: Early Typical Late
- First spoken sentences: Early Typical Late
- Does this student have any trouble:
 - Making certain speech sounds? No Yes
 - Understanding language? No Yes
 - Describing events and/or telling a story coherently? No Yes
 - Hearing subtle differences in words (e.g. pin/pen)? No Yes
 - Tended to use somewhat odd phrases? No Yes
 - Tend to repeat the same phrase over and over? No Yes
 - Engage in "small talk" or use language primarily to participate in a social interchange? No Yes
 - Participate in reciprocal conversation with peers? No Yes
 - Use socially inappropriate questions or statements? No Yes
 - Sometimes use words that are odd or made up? No Yes
 - Regularly talk outloud to him/herself? No Yes
 - Uses inappropriate volume, rate, or pitch in speech? No Yes
- Have difficulty communicating with other's his/her own age? No Yes
- Overall, do you feel that this student's language development was:
 - Slower than peers
 - About the same as peers
 - Ahead of peers
- Student's primary language: English Other: _____
- Languages spoken in the home: English Other: _____

Motor Development

- Sitting alone: Early Typical Late
 - Crawling: Early Typical Late
 - Standing alone: Early Typical Late
 - Walking alone: Early Typical Late
 - Does this student have difficulty with *gross motor tasks*, e.g. balancing, hopping, running?
 No Yes If yes, please explain: _____
 - Do you have concerns about this student's *fine motor* abilities, e.g. cutting, eating, writing?
 No Yes If yes, please explain: _____
- Overall, do you feel that this student's motor development was:
- Slower than peers About the same as peers Ahead of peers

Medical History

Physician/Pediatrician

- Name: _____ Address: _____
- City: _____ Zip: _____ Phone: () _____

Other Professionals

- Type of Service: _____
- Name: _____ Address: _____
- City: _____ Zip: _____ Phone: () _____
- Type of Service: _____
- Name: _____ Address: _____
- City: _____ Zip: _____ Phone: () _____

Health Record

- Date of last physical: _____
- Please describe this student's current health: _____

- Does this student have any health problems that need to be addressed? _____

- Please rate this student's overall diet: Good Average Poor
- Hearing: Normal Below average Wears aid Date of last check: _____
- Vision Normal Below average Wears glasses Date of last check: _____
- Current height: _____ Current weight: _____
- How many cups of caffeinated beverages does your child drink a day? _____

Medications

- Please list any prescription medications this student is currently taking (e.g., stimulants, anti-depressants, tranquilizers, painkillers): _____

- List any medications this student child has taken regularly in the past: _____

Conditions

- Has this student ever suffered from any of the following? (*check all that apply*)

Condition:	When?	Comments:
<input type="checkbox"/> Accidents		
<input type="checkbox"/> Allergies		
<input type="checkbox"/> Asthma		
<input type="checkbox"/> Ear Infections		
<input type="checkbox"/> Head Injuries		
<input type="checkbox"/> Hospitalizations		
<input type="checkbox"/> Neurological Sx's		
<input type="checkbox"/> Other Injuries		
<input type="checkbox"/> Seizures		
<input type="checkbox"/> Thyroid Problems		
<input type="checkbox"/> Tics		
<input type="checkbox"/> Other		
<input type="checkbox"/> Other		

Psychiatric History

Family Mental Health History

- Has anyone in your *immediate or extended biological family* ever suffered from:

Condition:	Who?	Comments:
<input type="checkbox"/> Abuse Issues		
<input type="checkbox"/> ADHD/ADD		
<input type="checkbox"/> Alcoholism		
<input type="checkbox"/> Anxiety		
<input type="checkbox"/> Asperger's/Autism		
<input type="checkbox"/> Bipolar Disorder		
<input type="checkbox"/> Depression		
<input type="checkbox"/> Epilepsy/Seizures		
<input type="checkbox"/> Learning Disability		

<input type="checkbox"/> Psychosis		
<input type="checkbox"/> Substance Abuse		
<input type="checkbox"/> Suicidal Behavior		
<input type="checkbox"/> Other		

- Please list any past or current psychological or emotional difficulties: _____

Behavior Checklist *(Please check all areas that are currently concerning you)*

- | | | |
|---|--|---|
| <input type="checkbox"/> Aggression toward others | <input type="checkbox"/> Lying | <input type="checkbox"/> Substance abuse |
| <input type="checkbox"/> Aggression toward self | <input type="checkbox"/> Oppositional | <input type="checkbox"/> Tearfulness |
| <input type="checkbox"/> Anxious | <input type="checkbox"/> Passive/Withdrawn | <input type="checkbox"/> Temper tantrums |
| <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Physical complaints | <input type="checkbox"/> Tired |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Separation difficulties | <input type="checkbox"/> Trouble with law |
| <input type="checkbox"/> Eating problems | <input type="checkbox"/> Sexual acting out | <input type="checkbox"/> Truancy |
| <input type="checkbox"/> Fears | <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Finger sucking | <input type="checkbox"/> Stealing | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Immature | <input type="checkbox"/> Stuttering/Tics | |

Attentional Checklist *(Please check all areas that begun prior to age seven and those items that are a current concern)*

- Is your child a video game player? No Yes, hours per day: _____
- What level video game player? Beginner Intermediate Advanced

Inattention

Before Present Behavior age 7		
<input type="checkbox"/>	<input type="checkbox"/>	Often fails to give close attention to details or makes careless mistakes.
<input type="checkbox"/>	<input type="checkbox"/>	Frequently has difficulty sustaining attention in tasks.
<input type="checkbox"/>	<input type="checkbox"/>	Regularly does not seem to listen when spoken to directly.
<input type="checkbox"/>	<input type="checkbox"/>	Repeatedly does not follow through on instructions and fails to finish tasks.
<input type="checkbox"/>	<input type="checkbox"/>	Has difficulty getting organized.
<input type="checkbox"/>	<input type="checkbox"/>	Avoids or dislikes tasks that require sustained mental effort.
<input type="checkbox"/>	<input type="checkbox"/>	Often loses things necessary for tasks or activities.
<input type="checkbox"/>	<input type="checkbox"/>	Is easily distracted by noises outside (e.g. birds, voices next door, cars).
<input type="checkbox"/>	<input type="checkbox"/>	Is frequently forgetful in daily activities.

<input type="checkbox"/>	<input type="checkbox"/>	Tunes in and out or drifts away in conversations.
<input type="checkbox"/>	<input type="checkbox"/>	Needs to reread a paragraph or page because of daydreaming.
<input type="checkbox"/>	<input type="checkbox"/>	Hard to attract his/her attention.
<input type="checkbox"/>	<input type="checkbox"/>	Loses attention unless very interested.
<input type="checkbox"/>	<input type="checkbox"/>	Yawns, stretches, or looks tired while doing “boring” tasks.
<input type="checkbox"/>	<input type="checkbox"/>	Has trouble awaking in the morning.
<input type="checkbox"/>	<input type="checkbox"/>	“Multitasks” to keep focused on certain tasks (rapid shifting of attention from one task to another; doing several things at once).

Hyperactivity

Before Present Behavior		
age 7		
<input type="checkbox"/>	<input type="checkbox"/>	Excessively restless (fidgets, squirms, shakes leg, taps feet, paces, doodles).
<input type="checkbox"/>	<input type="checkbox"/>	Trouble sitting still (compared to peers).
<input type="checkbox"/>	<input type="checkbox"/>	Must be doing something nearly all the time.
<input type="checkbox"/>	<input type="checkbox"/>	Is often “on the go” or often acts as if “driven by a motor.”
<input type="checkbox"/>	<input type="checkbox"/>	Talks excessively.
<input type="checkbox"/>	<input type="checkbox"/>	Takes on projects simultaneously, but has trouble finishing them on time.
<input type="checkbox"/>	<input type="checkbox"/>	Is frequently in search for high stimulation.
<input type="checkbox"/>	<input type="checkbox"/>	Has a hard time relaxing.
<input type="checkbox"/>	<input type="checkbox"/>	Is generally impatient.
<input type="checkbox"/>	<input type="checkbox"/>	Changes the radio station or TV stations frequently.

Impulsivity

Before Present Behavior		
age 7		
<input type="checkbox"/>	<input type="checkbox"/>	Has a tendency to say what comes to mind without necessarily considering the timing or appropriateness of the remark.
<input type="checkbox"/>	<input type="checkbox"/>	Has trouble waiting for his/her turn.
<input type="checkbox"/>	<input type="checkbox"/>	Tends to interrupt others.
<input type="checkbox"/>	<input type="checkbox"/>	Has trouble going through established channels in getting things done.
<input type="checkbox"/>	<input type="checkbox"/>	Is frequently impatient and has a low frustration tolerance.
<input type="checkbox"/>	<input type="checkbox"/>	Is impulsive in the spending of money.
<input type="checkbox"/>	<input type="checkbox"/>	Is “hot-tempered.”
<input type="checkbox"/>	<input type="checkbox"/>	Is intolerant of boredom.
<input type="checkbox"/>	<input type="checkbox"/>	Has a tendency toward addictive behavior.
<input type="checkbox"/>	<input type="checkbox"/>	Has a very hard time reading directions first.
<input type="checkbox"/>	<input type="checkbox"/>	Feels like exploding inside when someone has trouble getting to the

		point.
<input type="checkbox"/>	<input type="checkbox"/>	Often gets involved in a situation without having planned it out.
<input type="checkbox"/>	<input type="checkbox"/>	Has trouble keeping secrets.
<input type="checkbox"/>	<input type="checkbox"/>	Is accident-prone.

Other

Before Present Behavior age 7		
<input type="checkbox"/>	<input type="checkbox"/>	Has an ability to “hyperfocus” on some activities (e.g. video games).
<input type="checkbox"/>	<input type="checkbox"/>	Has problems with self-discipline.
<input type="checkbox"/>	<input type="checkbox"/>	Often procrastinates.
<input type="checkbox"/>	<input type="checkbox"/>	Has trouble getting started on things
<input type="checkbox"/>	<input type="checkbox"/>	Has trouble with time-management.
<input type="checkbox"/>	<input type="checkbox"/>	Has trouble organizing (keeping an updated calendar or checkbook).
<input type="checkbox"/>	<input type="checkbox"/>	Works best in short spurts followed by a break.
<input type="checkbox"/>	<input type="checkbox"/>	Has a history of underachievement.
<input type="checkbox"/>	<input type="checkbox"/>	Has mood swings, mood lability.
<input type="checkbox"/>	<input type="checkbox"/>	Has chronic problems with self-esteem.
<input type="checkbox"/>	<input type="checkbox"/>	Has difficulty making himself understood to others.
<input type="checkbox"/>	<input type="checkbox"/>	Is drawn to situations of high intensity.
<input type="checkbox"/>	<input type="checkbox"/>	Is unable to estimate time and space well.

Academic History

Early Education

- Was this student read to nightly as a child? No Yes
- Was this student able to listen and attend to stories? No Yes
- Did this student attend preschool? No Yes Type: _____
- Did this student attend kindergarten? No Yes Name: _____

Elementary School, Name: _____

- Type of school: Public Private
- Type of program: Regular education Special education Gifted program
- Type of program: Regular classroom Regular classroom with resource room
- Type of program: Special day class (SDC) Resource Room with mainstreaming
- Number of students in the classroom: _____

Middle School, Name: _____

- Type of school: Public Private

- Regular education Special education Gifted program
- Type of program: Regular classroom Regular classroom with resource room
- Special day class (SDC) Resource Room with mainstreaming

High School, Name: _____

- Type of school: Public Private
- Regular education Special education Gifted program
- Type of program: Regular classroom Regular classroom with resource room
- Special day class (SDC) Resource Room with mainstreaming

Special Services (*Please check all special services this student has received*)

Service	Current	Past	Frequency/Comments
Speech/Language	<input type="checkbox"/>	<input type="checkbox"/>	
Counseling	<input type="checkbox"/>	<input type="checkbox"/>	
Peer tutoring	<input type="checkbox"/>	<input type="checkbox"/>	
Adaptive P.E.	<input type="checkbox"/>	<input type="checkbox"/>	
Educational therapy	<input type="checkbox"/>	<input type="checkbox"/>	
Teacher help	<input type="checkbox"/>	<input type="checkbox"/>	

- Does this student have an *Individual Education Plan (IEP)* written at school? No Yes
- List any special accommodations this student is receiving at school: _____

School Performance

Please rate this student's academic skills and supply a copy of his/her most recent report card.

Academic Skill	Superior	Above Average	Average	Below Average	Very Poor	Typical Grade	Current Grade
Reading							
Spelling							
Writing							
Math							
Science							
Social Science							

Please rate this student's scores on *Standardized Achievement Testing* and please supply a copy.

Test Area	Superior	Above Average	Average	Below Average	Very Poor
Reading					
Spelling					
Writing					
Math					
Science					

Social Science					
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Please check any learning issues that apply to this student.

Learning issues	
<input type="checkbox"/>	Slow to learn the connections between letters and sounds.
<input type="checkbox"/>	Trouble learning to blend sounds to make words.
<input type="checkbox"/>	Makes consistent reading and spelling errors.
<input type="checkbox"/>	Problems remembering sequences.
<input type="checkbox"/>	Trouble learning to tell time.
<input type="checkbox"/>	Slow to learn new skills.
<input type="checkbox"/>	Has difficulty planning.
<input type="checkbox"/>	Slow to learn prefixes, suffixes, root words, and other reading strategies.
<input type="checkbox"/>	Avoids reading out loud.
<input type="checkbox"/>	Has difficulty with word problems in math.
<input type="checkbox"/>	Avoids reading and writing tasks.
<input type="checkbox"/>	Works slowly.
<input type="checkbox"/>	Has difficulty understanding and/or generalizing concepts.
<input type="checkbox"/>	Frequently misreads directions/information.
<input type="checkbox"/>	Confuses the order of letters in words.
<input type="checkbox"/>	Doesn't recognize words previously learned.
<input type="checkbox"/>	Doesn't recognize the correct spelling of words.

- Does this student demonstrate visual perceptual difficulties (e.g., letter reversals; confusion between similar letters such as b/d or p/q, words, or numbers; problems copying from the board; difficulty lining up math problems) No Yes
- Has this student demonstrated auditory processing difficulties (e.g., inconsistent following long oral directions; confusing similar sounding words such as mail and nail) No Yes
- Does this student miss school regularly? No Yes If yes, Please explain:

- Has this student had disciplinary problems? No Mild Moderate Severe
- Has this student ever been: Expelled Suspended In Saturday School
- Has this student been retained? No Yes, grade: _____
- Do you think this student has had a strong education to date? No Yes
- Importance of this student's education: Extreme Moderate Mild
- Please describe this student's current adjustment to school: _____

Personality and Social Relationships

- Please describe this student's personality and observed self-esteem: _____

- What are this student's favorite activities/interests? _____

- How does this student respond to chores? _____

- What are this student's strengths? _____

- What are this student's weaknesses? _____

- Does this student: *(Please check all that apply)*
 - Seem aware of his/her strengths or weaknesses.
 - Actively participate in important decisions that affect his/her life.
 - Persist in spite of adversity.
 - Have ways of dealing with stress.
 - Set reasonable goals and understand the step-by-step process of attaining goals.
 - Have significant others who hold clear, realistic expectations.
 - Receive and utilize support, guidance, and encouragement from significant others.

Peer Relationships

- Does this student:
 - Look directly in the eyes of people they are talking with? No Yes
 - Does this student offer to share with others? No Yes
 - Offer comfort to other's who are hurting? No Yes
 - Demonstrate a normal range of facial expressions? No Yes
 - Have facial expressions that are appropriate for content? No Yes
 - Display social responses that are generally appropriate? No Yes
 - Show interest in peer's his/her own age? No Yes
 - Engage in group play with other's his/her age? No Yes
 - Is often engaged in internal fantasy/dialogue? No Yes
 - Have unusual interests or behaviors? No Yes
 - Exhibit intense special interests? No Yes
 - Repetitively use objects or is preoccupied by certain parts of objects (e.g., spinning wheels of a car, open/shutting its doors)? No Yes
 - Become easily over stimulated in play (maybe leading to jumping up and down or flapping hands or arms)? No Yes

- This student: Prefers to play alone Has one or two friends only Has many friends
 - This student plays mostly with other children who are: Younger Same age Older
 - This student prefers to play with: Boys Girls Both genders
 - This student's friendships are: Very close Somewhat close Lacking in closeness
 - In general, friendships that this student forms last: Years Months Weeks Days
 - In play interactions with his/her peers, this student tends to:
 - Be the leader Prefer to be a co-leader Prefer others to lead
 - In competitive games, this student seems to: Need to win Want to win
 - Want to lose Be unconcerned about winning/losing.
 - In competition, this student: Does his/her best Gives up easily Performs below abilities.
 - This student has been bullied by others: No Yes If yes, please explain on back.
 - Please describe any difficulties this student may have with peer interactions: _____
-
- Do you have any concerns about this student's sexual development? No Yes

Independent Living Skills

- Please mark a in the box that best describes your child's ability to perform the following activities on the scale below:
 1. Completely Dependent or inappropriate (requires parent involvement and supervision)
 2. Slightly Dependent (initiates activity with some parent prompting and supervision)
 3. Developmentally appropriate (initiates and performs activity reasonably well)
 4. Slightly Advanced for age (initiates activity mostly by themselves)
 5. Completely Independent and appropriate (requires very limited parent prompting and does not require supervision)

Skill	1	2	3	4	5	Comments
General Hygiene						
Sexual Hygiene						
Shopping						
Cooking						
Cleaning						
Transportation						
Organization						
Time management						
Self-discipline						

Additional Information

Please use the back of this page to include any additional information that you think I should know.