FOCUS Progress Check-In

Please rate your impressions about the following for _____
This form is being completed by _____

Initial check-in please enter a check mark √ in the initial column if applicable at this time.

For 3 to 12 month check-in please enter **B** for **B**etter, **U** for **U**nchanged or **W** for **W**orse for the items that were originally indicated as applicable.

Date Completed	☐ Initial	☐ 3 mo	☐ 6 Mo	☐ 9 Mo	☐ 12 Mo
Getting to Sleep	_____	_____	_____	_____	_____
Quality of Sleep	_____	_____	_____	_____	_____
Amount of Sleep	_____	_____	_____	_____	_____
Limited Food Choices	_____	_____	_____	_____	_____
Eating Habits	_____	_____	_____	_____	_____
Digestive Health Overall	_____	_____	_____	_____	_____
Frequency of Bowel Movements	_____	_____	_____	_____	_____
Feelings About School	_____	_____	_____	_____	_____
Ease with Completing Homework	_____	_____	_____	_____	_____
Ability to Concentrate on a Task/Goal	_____	_____	_____	_____	_____
Handwriting	_____	_____	_____	_____	_____
Reading Comprehension	_____	_____	_____	_____	_____
Organization/Planning	_____	_____	_____	_____	_____
Spelling	_____	_____	_____	_____	_____
Understanding Concepts	_____	_____	_____	_____	_____
Vocabulary and Expression	_____	_____	_____	_____	_____
Attention/Focus	_____	_____	_____	_____	_____
Academic Performance/Grades	_____	_____	_____	_____	_____

Continued, please Enter **B** for **B**etter, **U** for **U**nchanged or **W** for **W**orse.

	Initial	3 mo	6 Mo	9 Mo	12 Mo
Participation in Extra Curricular Activities	_____	_____	_____	_____	_____
Relationships with Peers	_____	_____	_____	_____	_____
Sensory Sensitivity	_____	_____	_____	_____	_____
Mood (self-esteem)	_____	_____	_____	_____	_____
Anxiety	_____	_____	_____	_____	_____
Rigidity/Demand for Sameness	_____	_____	_____	_____	_____
Sensitivity to Pain	_____	_____	_____	_____	_____
Energy Level	_____	_____	_____	_____	_____
Family Relationships	_____	_____	_____	_____	_____
Loses Temper/Emotional Outbursts	_____	_____	_____	_____	_____
Ability to Self-Regulate Emotions	_____	_____	_____	_____	_____

Please complete the following section at the 3 month, 6 month, 9 month and 12 month evaluation only.

Other areas of noted improvement since starting FOCUS:

3 month

6 month

9 month

12 month

Other areas of concern:

3 month

6 month

9 month

12 month

Have you been using any new dietary interventions? If so, please describe.

3 month

6 month

9 month

12 month

Did you add or remove any supplements? If so, please list.

3 month

6 month

9 month

12 month

Please rate your level of satisfaction with the FOCUS program on a 1 to 10 scale (10 highly satisfied to 1 greatly dissatisfied)

3 mo _____ 6 Mo _____ 9 Mo _____ 12 Mo _____

Would you recommend this program to others? Yes or No

3 mo _____ 6 Mo _____ 9 Mo _____ 12 Mo _____

Your feedback is valued and important to us, the information we are receiving from you will help to provide additional data to be used anonymously for our records. We thank you kindly for your time.