

**Kerri Golding, LCSW**  
CHILD, ADOLESCENT & ADULT THERAPIST

**CLASSROOM FOLLOW-UP EVALUATION**

Name: of student \_\_\_\_\_ Grade \_\_\_\_\_

Teacher \_\_\_\_\_ Date of evaluation \_\_\_\_\_

If you have the student all day, please indicate whether there is a difference in the morning (AM) or afternoon (PM)

	NO IMPROVEMENT <b>AM/PM</b>	SLIGHT IMPROVEMENT <b>AM/PM</b>	MODERATE IMPROVEMENT <b>AM/PM</b>	SIGNIFICANT IMPROVEMENT <b>AM/PM</b>
1. Task Completion	___/___	___/___	___/___	___/___
2. Concentration	___/___	___/___	___/___	___/___
3. Disruption of Class	___/___	___/___	___/___	___/___
4. Impulsivity	___/___	___/___	___/___	___/___
5. Homework Completion	___/___	___/___	___/___	___/___
6. Difficulty Learning	___/___	___/___	___/___	___/___
7. Distractibility	___/___	___/___	___/___	___/___
8. Peer Relationships	___/___	___/___	___/___	___/___

Time of Class: \_\_\_\_\_

Grades:

Teachers Comments: