TREATMENT TRIAL FORM:

Child's name: _____Grade: _____ Year: _____

Person completing this form: _____

Relation to child: _____

When were your observations usually made? (Circle):

mornings/ afternoons/ evenings/ weekdays/ weekends

Dear Parents, Teachers, and Child:
Thank you very much for your help. It is so important to conduct this trial in a careful and controlled fashion. Please complete the table below. **Observations will be recorded for the preceding: day/ week/ month (circle one)**. *If you were not able to make observations during that period, leave the column blank. Your comments in narrative form are also very helpful. On the back, please record the date and provide general impressions, including the following: Were there any problems with the treatment? Were there any benefits? Give details. Please call me if you have any questions or concerns. Thank you.*

During the observation period, how big were these problems?
0=no problem, 1= little problem, 2=medium problem, 3=big problem

STRATEGY for:	baseline									
Targets **DATE**										
Possible Side Effects										