



ESSENCE-Q-REV (Gillberg C 2012)



Name of child:	
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Age:		Completed by:	
Sex:		Date:	

Please take a few minutes to read and check the following items.

- ❖ **Y= Yes**
- ❖ **M/AL = Maybe/A little**
- ❖ **N= No**

Have you (or anybody else, who? _____) been concerned for more than a few months regarding child's

- | | |
|---|--------------------------|
| 1. General development | <input type="checkbox"/> |
| 2. Motor development/ milestones | <input type="checkbox"/> |
| 3. Sensory reactions (e.g. touch, sound, light, smell, taste, heat, cold, pain) | <input type="checkbox"/> |
| 4. Communication/language/ babble | <input type="checkbox"/> |
| 5. Activity (overactivity/passivity) or impulsivity | <input type="checkbox"/> |
| 6. Attention/concentration/ "listening" | <input type="checkbox"/> |
| 7. Social interaction/interest in other children | <input type="checkbox"/> |
| 8. Behaviour (e.g. repetitive, routine insistence) | <input type="checkbox"/> |
| 9. Mood (depressed, elated/manic, extreme irritability, crying spells) | <input type="checkbox"/> |
| 10. Sleep | <input type="checkbox"/> |
| 11. Feeding | <input type="checkbox"/> |
| 12. "Funny spells"/ absences | <input type="checkbox"/> |

If Y or M/AL to any of the above, please elaborate briefly here:
