5 Days to More Talking Coaching Week

WORKBOOK

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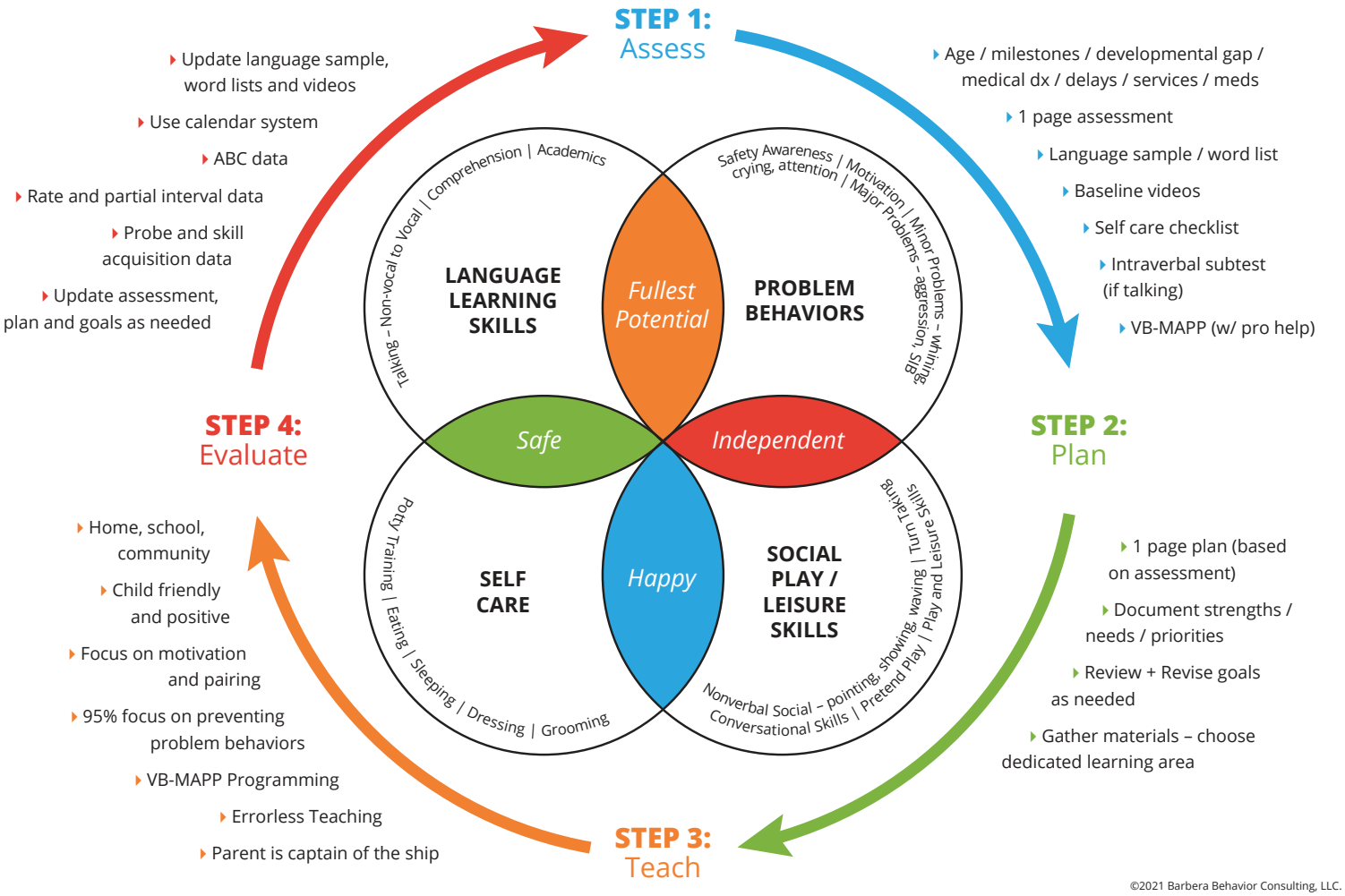
Turn Autism Around® Approach

By Dr. Mary Barbera



Download this resource here.

Name: Child 1 DOB: 09/15/XX Age: ___yrs ___mo **1 hour - 09/15/XX, 12-1 PM Family Room** No words or sounds heard.
Name: Child 2 DOB: 03/20/XX Age: ___yrs ___mo **15 minutes - 06/16/XX, 8:30-8:45 AM Kitchen** Ba ba ba, *while reaching for bottle* Ooo Ahh Mama, *when shown picture of Mom*
Name: Child 3 DOB: 05/14/XX Age: ___yrs ___mo **30 minutes - 09/17/XX, 2:00-2:30 PM Outside** Slide Push me I want swing Go, with prompting of "ready, set, ___" Open Mommy go in

Download this resource here.

Language Sample Form

by Dr. Mary Barbera

Name: _____ **DOB:** _____ **Age:** ___yrs ___mo

Date : _____ **Start Time:** _____ **End Time:** _____ **Duration:** _____

Name of Person Recording Data: _____

Date : _____ **Start Time:** _____ **End Time:** _____ **Duration:** _____

Name of Person Recording Data: _____

Date : _____ **Start Time:** _____ **End Time:** _____ **Duration:** _____

Name of Person Recording Data: _____

Download this resource here.

Turn Autism Around ® Assessment by Dr. Mary Barbera

General information

Date of completion **07/11/2023**
Person completing
Parent/Guardian
First name of person completing assessment **RSS**
Child's first name or initials
EJS
Date of birth **04/02/2019**
Age yrs **4**
Age months **3**

Medical Information

Does your child have a diagnosis of autism? **NO**
Age at autism diagnosis - years
Age at autism diagnosis - months
Does your child have any of these diagnosis? **Speech Delay**
Does your child recieve any therapy or special education services currently? **NO**
Is your child on any medication?
NO
Does your child have allergies?
YES
if yes, what type of allergies?
Medication
if yes, is your child on any allergy medication or shots? **NO**
Is your child on a special diet?
NO

Safety Concerns

Do you have safety awareness concerns? **YES**
If yes, check all that apply
Traffic,Water

Self-Care and Daily Living Tasks

Does your child have any eating or drinking problems? **YES**
If yes, what type of eating or drinking problems? **Picky eater (limited diet),Does not drink from an open cup**
Does your child have sleeping issues? **YES**
If yes, what type of sleeping issues? **Trouble falling asleep,Requires sleep medication or supplements**
Does your child have any problems with using the potty/toilet? **YES**
If yes, check one **child is pee trained but not poop trained**
Does your child have difficulty with dressing and grooming? **YES**
if yes, check all that apply
refuses and or needs total assistance with tooth brushing

Language and Learning Skills

Does your child ever use any words? **YES**
If yes, approximately how many different words does your child say on a daily basis? **20-50**
If yes, does your child string 2 or more words together? **YES**
If yes, how often do you hear your child use 2 or more word phrases? **sometimes**
If yes, Is your child fully conversational (back and forth exchanges with full sentences)?
NO

Requesting / Manding

Can your child ask for things he/she wants with words? **YES**
If yes, how often? **sometimes**

Labeling / Tacting

Can your child label things in a book or on flashcards? **YES**
If yes, approximately how many different items can the child label on a daily basis? **11-20**
Which, if any, abstract concepts can your child label? **Labels colors**

Verbal Imitation / Echoics

Can your child imitate words you say? **YES**
Imitates single words? **YES**
Imitates phrases? **YES**
Does your child say things he/she has memorized from movies or things he/she has heard you say in the past? **YES**

Answering Questions / Intraverbals

Can your child fill in the blanks to songs? **YES**
Will your child fill in the blanks to fun and/or functional phrases? **YES**
Will your child answer WH questions (with no picture or visual clues)? **NO**

Listening / Receptive Language

Does your child respond to his/her name when you call it?
Often
If you tell your child to get his/her shoes or pick up his/her cup, does he/she follow your direction without gestures?
Rarely
If you tell your child to clap his/her hands or stand up will he/she do it without gestures?
Rarely
Will your child touch his/her body parts, for example, if you say "Touch your nose?" **YES**

Imitation

Will your child copy your actions with toys if you tell him/her "Do this"? **YES**
Will your child copy motor movements if you tell him/her "Do this"? **YES**

Visual / Matching

Will your child match identical objects to objects, pictures to pictures, and pictures to objects if you tell him/her to "match"?
YES
Will your child complete age-appropriate puzzles? **Not Yet**

Social / Play Concerns

Do you have concerns about your childs ability to socialize and/or play? **YES**
- **Taking turns,Sharing,Pretend play**

Problem Behavior

and do simple tasks with an adult? **YES**
If yes, how long can they stay engaged with an adult at a table or on the floor without problem behavior? **5-15 minutes**
Please select any minor problem behaviors your child exhibits **crying,whining,refusal**
How often does your child engage in minor problem behaviors throughout the day? **Sometimes**

(hitting/throwing)? **YES**
If yes, please select the major problem behaviors your child exhibits **dropping to the ground,property destruction (throwing/dumping/swiping/tearing)**
If yes, when/where do major problem behaviors occur? **transitioning away from preferred activity,during doctor/dentist**

If yes, how often does your ch engage in major problem behaviors? **a few times a week**

Turn Autism Around® Approach Resources

What Turn Autism Around (TAA) resources by Dr. Mary Barbera have you used? (Check all that apply) **Follow Dr. Mary Barber on social media**

TURN AUTISM AROUND® ASSESSMENT SCORES FOR EJS

OVERALL SCORE: 48%*

Self-Care and Daily Living Tasks: 36%

Language and Learning Skills: 62%

Problem Behaviors: 47%

Scores closer to 100% show more strengths in those areas. Scores lower than 85% in one, two or all three areas indicate need for improvement.

****Disclaimer****
This tool is not a standardized assessment and these scores are for informational purposes only. If you are concerned about your child's delays and/or problem behaviors please contact a medical and/or behavioral professional who can assist you with further assessment. But, don't wait and worry- join us today to start turning things around at marybarbera.com/courses.

Turn Autism Around Planning Form (Sample)

by Dr. Mary Barbera

Child's Name: Faith

Date of Birth: 1/5/XX

Age: 3 years 2 months

Date Form Completed: 4/20/XX

Strengths	Needs
• Can say 50 words • Can mand and tact • Feeds herself • Sleeps through the night • Responds to her name most of the time • Follows directions sometimes when accompanied by gestures	• Cannot echo/imitate • Cannot sing songs • Cannot match identical objects • Flops on the ground several times daily • Potty training

Plan

- Pair table and materials with reinforcement
- Learning time at the table daily
- Focus on echoic control and visual matching
- Collect data on language and problem behaviors

Download this resource here.

Turn Autism Around Planning Form

by Dr. Mary Barbera

Child's Name: _____ Date of Birth: _____ Date Form Completed: _____

Age: _____ years _____ months

Strengths	Needs

Plan

Download this resource here.

Here is a full list of resources from this workbook with some additional ones:

LANGUAGE SAMPLE FORMS:
Language Sample (Blank)
Language Sample (Sample)

ONE PAGE ASSESSMENT FORMS:
Take the Digital Assessment
Digital Assessment Form (Sample)

ONE PAGE PLANNING FORMS:
Planning Form (Blank)
Planning Form (Sample)

Join the Full Turn Autism Around® Course Now!

Start to Turn Autism Around®

using a child-friendly and proven approach to increase talking, decrease problem behaviors and improve picky eating, sleeping, potty training and more

...for parents and professionals helping kids with autism and toddlers showing signs

JOIN THE COURSE NOW