A Place for Children
2425 West Pratt Chicago, Illinois 60645
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773-338-5437

Dear Parent:

Your child has been referred for a developmental evaluation. This is because you, or your physician, have expressed some concerns about your child's progress in one or more areas of development, such as speech and language, walking and motor skills, school performance, or behavior.

This evaluation will be done by our Developmental Therapist, Erin Austria. It will usually be completed in one visit, but sometimes a follow-up visit may be needed. To make this evaluation most helpful, we need to obtain information about your child's health, developmental progress, and behavior, as well as his or her strengths and weaknesses in a number of areas. In order to make the best use of your time and ours, we ask that you provide us with some of this information beforehand, by completing this Child Development Questionnaire, and returning it to us before your child's appointment. Yes, the questionnaire is long and involved, but it is very important that you answer it completely. If you don't know the answer to any question, write "Unknown." If a question does not apply to your child, write "N/A." If there are some things you would prefer discussing in person with the physician, just note that on the form. Please bring the completed questionnaire with you to your visit. If you do not, you may be asked to fill out the questionnaire again.

Please feel free to call us at 773-338-5437 if you have difficulty completing the form, or if you have any questions.

Thank you for helping us to provide the best care for your family.

CHILD DEVELOPMENT QUESTIONNAIRE

This information is a very important part of your child's developmental evaluation. Please answer all questions as completely as you can. If you need more space to answer any question, please use the last page of the questionnaire.

Child's Full Name ____

Child's Birth Date ____________________ **Age** _______ **Today's Date** _____________________________

Name of Person(s) Completing this Form ____

Relationship to Child ____

What does your child like to be called? ____

Child's School (or Preschool) ____ **Grade** _________

Who referred you for this evaluation? ____

Father's Name ______________________________________ **Circle One:** Biological / Adoptive / Stepfather

Age ______ **School Level Completed** ____________________ **Employment** _________________________

Ethnic Background (optional) ____

Mother's Name _____________________________________ **Circle One:** Biological / Adoptive / Stepfather

Age ______ **School Level Completed** ____________________ **Employment** _________________________

Ethnic Background (optional) ____

Current Marital Status of Parents (circle one):

Married / Separated / Divorced / Living Together / Other _____________________________________

Date of Marriage _________________________ **Date of Divorce/Separation** _________________________

With whom does the child live? (e.g., both parents, step-parent, father, mother, grandparent, foster parents, etc.) ____

Who cares for the child during the day if the parents work?

____

Phone #: **Home** ____________________ **Work** _____________________ **Cell** _________________________

WHAT ARE YOUR CONCERNS?

Please list the concerns you have about your child. If there are things that concern other people (such as grandparents, a doctor, etc.) but that you think are OK, please include them, but check "Not concerned."

Problem	Age Noted	Diagnosis	Not Concerned

Do you have any other concerns about your child's development or behavior?

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Has your child had any evaluation, testing, or treatment related to these concerns?

Date	Location	Diagnosis/What were you told?/What was done?

MOTHER’S PREGNANCY HISTORY

(If the child's mother is not completing this form, please provide as much information as possible)

Child's Name	Date of Birth	Health or Developmental Problems?

MOTHER'S PRENATAL HISTORY

(If the child's mother is not completing this form, please provide as much information as possible)

Did you take vitamins and iron during this pregnancy? (circle one) Y N

Please list any other medications or drugs taken during this pregnancy, including supplements:

____

Did you smoke cigarettes during this pregnancy? (circle one) Y N

Did you drink alcohol before and/or during this pregnancy? (circle one) Y N

If you stopped during your pregnancy, in which month did you stop? ______________________________

Please describe any problems with the pregnancy:

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Was the child born within two weeks of your due date? (circle one) Y N

If Not: _______ Weeks Early _______ Weeks Late Gestational Age, if Known______________________

How long was your labor? ______________ **How was your child delivered?** _________________________

Please describe any problems with the delivery:

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YOUR CHILD'S BIRTH **(Include as much information as you know.)**

Birth Weight __________ Length __________ Head Circumference __________ Apgar Scores ________

Please describe your child's condition at birth and in the nursery. Explain anything to which you marked a "Y."

	Y	N
Breathed Immediately		
Cried Immediately		
Required resuscitation in the delivery room		
Had seizures/convulsions		
Had infection (blood, pneumonia, etc.)		
Low blood sugar		
Jaundice		
Needed help with breathing (CPAP or		
Fed by tube through nose or mouth		
Fluids or medications by IV or catheter		
Phototherapy (special lights) for jaundice		

Went home at ______ days of age. Home with mother? (circle one) Y N

Any other problems in the newborn period? (For example, surgery, transfer to another hospital, special tests, etc.) ____

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YOUR CHILD'S NUTRITION

Breast fed? (circle one) Y N **How long?** ____

Formula Fed? (circle one) Y N **How long?** ____

Any difficulties with feeding as an infant? (Slow feeder, choking, difficulty swallowing, food intolerance, food allergy, colic, etc.) (circle one) Y N

If so, please explain:

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*__Were there concerns about how well the baby was gaining weight?__ (circle one) Y N

If so, please explain:

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***Do you have any concerns about your child's eating or nutrition now?** (circle one) Y N

If so, please explain:

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YOUR CHILD'S HEALTH

Who is your child's regular physician? ____

What other physicians or therapists does your child see regularly (including counseling or mental health practitioners)? ____

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Does your child have a diagnosed medical condition, syndrome, or disorder? (circle one) Y N

If so, please describe: ____

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When was your child's last well child visit (checkup)? ______________________________________

Is your child missing any immunizations? (circle one) Y N

Please circle any of the following conditions that your child has, or had in the past:

Frequent Ear Infections	Frequent Vomiting	Broken Bones	Muscle Problems
Frequent Colds	Seizures	Limp	Eye Problems
Pneumonia	Meningitis	Difficulty Walking	Constipation
Bronchitis	Headaches	Drooling	Hearing Problems
Asthma	Breath-Holding Spells	Joint Problems	Dental Problems
Chronic Diarrhea	Loss Of Consciousness	Arthritis	Poor Weight Gain
Chronic Skin Problems	Head Injury	Anemia	Eating Non-Food Items
Heart Disease	Kidney Disease	Thyroid Disease	Hospitalized Overnight
Severe Reaction to Medication, Immunization, or Injection	Large or Multiple Birthmarks	Major or Minor Surgery	

Please explain any of the above, or list other medical diagnoses or conditions:

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Has your child's hearing been tested? (circle one) Y N Result ______________________________

Has your child's vision been tested? (circle one) Y N Result _______________________________

Is your child currently taking any medication? (circle one) Y N

Medication	Dose	Reason/Condition

Does your child take any over-the-counter medications, nutritional supplements, or other treatments on a regular basis? (circle one) Y N

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YOUR CHILD'S EARLY DEVELOPMENT

Please note the age at which your child first did each of the following. Please try to be as accurate as possible, by using baby books, asking relatives, etc. Put "not yet" if he/she does not do this.

Sat up without Help _____________ **Crawled** _______________ **Walked Alone** ________________

Used a Spoon ______________ **Drank from Regular Cup** ____________________________________

Said First Word ______________ **Put Two Words Together** ("my ball," "mommy go") ____________

Recited Alphabet _____________ **Counted to Ten** ______________ **Read Words** _______________

***Has your child lost any skills?** (Are there things that he/she used to be able to do but doesn't or can't do anymore?) (circle one) Y N

Explain:

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YOUR CHILD'S BEHAVIOR

EARLY BEHAVIOR:

Please note if any of the following were a problem or concern during the first 2 years of your child's life:

	Not a Problem	Mild or Occasional Problem	Big Problem
1. Feeding difficulties			
2. Sleeping difficulties			
3. Rhythmic behaviors (i.e. head banging)			
4. Hard to console or comfort			
5. Floppy			
6. Excessive crying			
7. Not interested in other people			
8. Not affectionate			

Please explain any of the above:

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PRESENT BEHAVIOR: (Skip this section if your child is less than 2 years old.)

Please note if any of the following are a problem or concern for your child now, more than for other children his/her age.

	Not a Problem	Mild or Occasional Problem	Big Problem
1. Sensitive, cries easily			
2. Often seems confused			
3. Sleeps poorly			
4. Often tired			
5. Demands attention			
6. Often sad			
7. Often wets pants or bed			
8. Bowel movement accidents			
9. Sucks thumb or other objects			
10. Refuses to obey			
11. Tells lies frequently			
12. Very shy			
13. Temper tantrums			
14. Hurt people or damaged property			
15. Anxious or nervous			
16. Uses peculiar speech			
17. Cruel to animals			
18. Unusual fears			
19. Difficulty making or keeping friends			
20. Nervous habits or tics			

Please explain any of the above:

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FAMILY HISTORY

Child's Biological Father:
School Level Completed ________________________ **Present Occupation** ______________________

Child's Biological Mother:
School Level Completed ________________________ **Present Occupation** ______________________

Are this child's parents blood-related? (circle one) Y N

Please indicate if any family members have had:

Condition	Child's Father	Child's Mother	Child's Brother(s)	Child's Sister(s)	Grandparents, Aunts, Uncles
1. Speech problems					
2. Hyperactive as a child					
3. Problems with coordination					
4. Difficulty learning to read					
5. Difficulty with spelling					
6. Difficulty with arithmetic					
7. Special education					
Behavior problems as a child					
9. In trouble as a teenager					
10. Kept back in school					
1. Mental retardation					
2. Mental illness or disorder					
3. Birth defects					
4. Seizures/convulsions					
5. Neurological disorder					
6. Muscle disease					
7. Genetic disorder					
8. Thyroid disorder					
11. Hearing problem					
13. Death in infancy					

Please give details if known: ____

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YOUR CHILD'S SCHOOL

(Skip this section if your child is not yet attending school)

Present School _________________________________ **Location** ________________________________

Principal ________________________________ **Teacher**_______________________________________

Home Schooled? (circle one) Y N
If Yes, which curriculum do you use? ____

Has your child ever repeated a grade? (circle one) Y N Which one? ________________________

Is your child receiving special education services, or was he/she in the past? (circle one) Y N
If Yes, please explain: ____

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Have you ever been told that your child was having problems in school? (circle one) Y N
If Yes, please explain what you were told and what was (or is being) done:

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If your child has been having problems in school, please bring any school reports you have when you come for the developmental evaluation. This includes:

- Report Cards
- IEP's
- Teacher Reports
- Standardized Test Results: Cognitive (IQ), Achievement, Adaptive, etc.

SUMMARY

Please tell us your main concern(s) about your child.

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Is there anything that you think (or wonder) might have caused or contributed to the problem?

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What are your hopes and goals for your child?

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What do you think needs to be done in order to help your child achieve these goals?

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What do you think we might be able to offer you and your child?

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Is there anything that has not been covered in this questionnaire that you would like us to know, or that you think may be important regarding your child?

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Please feel free to use the rest of this page to give a more complete answer to any of the questions. Thank you very much for taking the time to complete this questionnaire. Please call us at 773-338-5437 if you have any questions.