HOME QUESTIONNAIRE

FOR DEVELOPMENTAL BEHAVIORAL & HEALTH ASSESSMENT

Child's Name:_____ Date of Birth:_____

Person Completing Form:_____ Telephone: (Hm)_____

Relationship to Child:_____ (Wk)_____

Date Form Completed:_____

If your child is in school, please complete the following:

Name of School:_____
Town:_____ Grade:_____
Teacher (s):_____

Please list any problem(s) with which you want help for this child:

*1.*_____

*2.*_____

*3.*_____

*4.*_____

Whose idea was it that this child have an evaluation?

_____

Has this child has previous evaluations outside of school? YES_____ NO_____

If so, where and when? Please bring any available report(s) to your appointment.

_____

_____

Has this child had any special treatments (diets, medications, counseling, psychiatric help, etc.)?
YES_____ NO_____
If so, please describe below:

Approximate Date(s) or age	Type(s) of Treatment (Include name(s) of any medicine you remember)

This Checklist concerns the pregnancy with this child, except for the last two items which refer to previous pregnancies. Please read each item and put an X in the appropriate column.

POSSIBLE PREGNANCY PROBLEMS	True	Not True	Can't Say
Had bleeding during first three months			
Had bleeding during second three months			
Had bleeding during last three months			
Gained 30 or more pounds (If so, how many pounds? _____)			
Gained less than 15 pounds (If so, how many pounds? _____)			
Had Toxemia			
Had to take medications (If so, please list below)			
Vomited often beyond first three months			
Got hurt or injured			
Took narcotic drugs			
Drank Alcohol			
Had an infection			
Smoked cigarettes			
Labor lasted longer than 12 hrs.			
Labor lasted less than 2 hrs.			
Had a cesarean section			
Had a difficult delivery			
Was put to sleep for delivery			
Length of pregnancy? _____months or _____weeks			
Had previous miscarriages			
Had previous premature baby (ies)			

Medication(s):_____

_____

Other pregnancy problems:_____

_____

This checklist is about the baby's *first month of life*. Please read each item and put an X in the appropriate column.

NEWBORN INFANT PROBLEMS	TRUE	NOT TRUE	CAN'T SAY
Born with a cord around neck			
Injured during birth			
Had trouble breathing			
Got yellow (jaundice) to the point of needing a blood exchange transfusion			
Got yellow (jaundice) to the point of needing phototherapy (bill-lights			
Turned blue (cyanosis)			
Was a twin or triplet			
Had an infection			
Was given medications			
Had seizures (fits, convulsions)			
Had diarrhea			
Needed oxygen			
Was in hospital longer than mother			
Gagged often			
Vomited often			
Born with a heart defect			
Born with other defect (s). If so, please describe:			
Had trouble sucking			
Had skin problems			
Was very jitter			
Baby's birth weight:_____lb _____ oz			

Please describe any other problems here: _____

_____

_____

_____

Following is a checklist of accomplishments of students. Please put an X next to each item under the column giving the age at which this "milestone" first occurred. Note that the first five columns are age in months and the last four columns are age in years.

	Months					Years			
EARLY DEVELOPMENT	**0-3**	**4-6**	**7-12**	**13-18**	**16-24**	**2-3**	**3-4**	**4-5**	**5-6**
Sat up without help									
Crawled									
Walked alone (10-15 steps)									
Walked up stairs									
Rode a tricycle									
Caught a big ball									
Spoke first words (Mama, Dada, ect.)									
Spoke 2-3 word sentences									
Spoke clearly so strangers understood									
Used fingers to feed self									
Used a spoon									
Fully bowel trained									
Fully bladder trained									
Able to dress self									
Able to tie shoelaces									
Able to separate easily from mother (for school, play, ect.)									

If you had any concerns regarding the development of this child, please describe below.

The following checklist is about any medical problems the child may have had. If your child has had any of these problems, please put an X in the column under the age at which the problem(s) occurred. If a problem occurred over a long period, or over and over again, please check the columns for each age during which the problem existed. If the child has never had a problem, put an X in the "Never" column.

		YEARS OF AGE				
HEALTH PROBLEMS	Never	0-1	1-5	5-10	10-15	15-
Ear Infection (s)						
Rashes or skin problems						
Meningitis						
Seizures (convulsions) or spells						
High fevers (over 105)						
Pneumonia						
Asthma						
Slow weight gain						
Trouble with hearing						
Trouble with vision						
Bowel problems						
Hospitalization(s) (If so , please describe below)						
Surgery (ies)						
Serious injury (ies)						
Food allergies						
Other allergies						
Anemia (low blood count)						
Lead, poisoning						
Other poisoning or overdose						
Heart problems						
Kidney or urinary problems						
Got sick after a shot (immunization)						
Other important illnesses (Please list) _____ _____						
Medication (s) used a over a long period (please list) _____ _____ _____						

Please describe any hospitalizations or surgeries:_____

Following is a checklist of several problems. We are interested in whether anyone in the family other than this student has had any of these. Please put an X in the column of the family member(s) who have or have had each problem. If more than one brother or sister has or has had one of these difficulties, put an X for each one in the appropriate column. the "Others" column (for family members such as cousins, aunts, uncles, grandparents) should be used in the same way.

FAMILY HISTORY	**Child's Mother**	**Child's Father**	**Child's Brother(s)**	**Child's Sister (s)**	**Others (Specify)**
Hyperactive as a child					
Trouble learning to read					
Trouble with arithmetic					
Trouble with writing					
Speech Problems					
Behavior Problems as a child					
In trouble as a teenager					
Kept back in school					
Mental Illness					
Depression					

Father's present age _____School level completed_____
Present occupation _____
General health _____
Mother's present age _____School level completed _____
Present occupation _____
General health _____
Brother (s): Age(s) _____
_____
Sister(s): Age(s) _____
_____

Please check any of the following that are true of this child:
_____Was adopted _____Is a foster child
Please check any of the following that are true of this child's parents:
_____Separated _____Divorced _____One or _____both parent(s) are deceased
Please check all of the following that describe this child's current living arrangements:
_____Lives with Mother _____Lives with Father _____Lives with Stepmother
_____Lives with Stepfather _____Lives with grandparent(s)_____
_____Lives with Other(s)

_____
How many people including children live in your household?_____

The following checklist includes some personality of or behavioral problems your child may have had. If your child has had any of these problems, please put an X in the column under the age at which the problem (s) occurred. If a problem occurred over a long period, or over and over again. Please check the columns for each age during which the problem existed. If the child has never had a problem, put and X in the "Never" column.

		YEARS OF AGE														
FUNCTIONAL PROBLEMS	Never	0-1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Feeding difficulty of eating a problem																
Poor appetite																
Unwillingness to try new foods																
Very unpredictable appetite																
Overeating																
Colic																
Constipation																
Abdominal pains																
Trouble falling asleep																
Trouble staying asleep																
very unpredictable length of sleep																
Very heavy sleeping																
Overactivity																
Head banging																
Rocking in bed																
Temper Tantrums																
Self-destructive behavior																
Difficulty in being comforted or consoled																
Looseness or floppiness																
Stiffness or rigidity																
Crying often and easily																
Shyness with strangers																
Bashfulness with new acquaintances																
Extreme reaction to noise or sudden movements																
Difficulty in keeping to a schedule																
Trouble getting satisfied																
Desire to be held too often																
Failure to be affectionate toward parents																
Unwillingness to go along with change in daily routine																

The following checklist is about any school problems your child has had any of these problems, please put an X in the column under the grade at which the problem (s) occurred. If a problem occurred over a long period, or over and over again, please check the columns for each grade during which the problem existed. If the child has never had a problem, put an X in the "Never" column.

SCHOOL PROBLEMS	Never	Pre-K	Kind	1	2	3	4	5	6	7	8	9	10	11	12
Reading															
Holding a pencil/pen properly															
Writing															
Writing cursive															
Writing words/sentences															
Math															
Telling time															
Knowing days of week, months															
Spelling															
Getting homework done															
Study habits															
Paying attention															
Behavior															
Following rules															
Obeying adults															
Getting along with other children															
Overactivity															

Please describe any additional concerns about school you have:_____

_____

_____

_____

Circle the number in the *one* column for each item which best describes the child. Please do not leave any items blank.

	NOT AT ALL	JUST A LITTLE	PRETTY MUCH	VERY MUCH
Often fidgets or squirms in seat	0	1	2	3
Has difficulty remaining seated	0	1	2	3
Is easily distracted	0	1	2	3
Has difficulty awaiting turn in groups	0	1	2	3
Often blurts out answers to questions	0	1	2	3
Has difficulty following instructions	0	1	2	3
Has difficulty sustaining attention to tasks	0	1	2	3
Often shifts from one uncompleted activity to another	0	1	2	3
has difficulty playing quietly	0	1	2	3
Often talks excessively	0	1	2	3
Often interrupts or intrudes on others	0	1	2	3
Often does not seem to listen	0	1	2	3
Often loses things necessary for tasks	0	1	2	3
Often engages in physically dangerous activities without considering consequences	0	1	2	3