

c. Do any of your children have difficulty in school/daycare:

Name	School	Difficulty
_____	_____	_____
_____	_____	_____
_____	_____	_____

d. Has any family member or close relative had significant difficulty in school?

If yes, Relationship: _____ Nature of Difficulty: _____

3. Parents:

a. _____ Married _____ Separated _____ Divorced _____ Widowed

b. Father's Name: _____ Occupation: _____

Place of Work: _____

c. Mother's Name: _____ Occupation: _____

Place of Work: _____

d. Highest grade completed: (circle)

Father: 7 or less 8 9 10 11 12 College: 1 2 3 4 more

Mother: 7 or less 8 9 10 11 12 College: 1 2 3 4 more

e. Other persons residing in the household:

Name (s): _____

Relationship (s): _____

f. Have there been any extraordinary events in this household? (e.g. illness, moves, death, disaster, change in make-up of family)

g. Any serious parental or family health problems? _____

4. Basic Medical Data:

a. Name of child's doctor: _____ Tele. #: _____

Address: _____

b. Name of child's dentist: _____ Tele. #: _____

Address: _____

g. At what age did this child begin walking? (give approximate age if you do not remember, label as such) _____

Do you feel your child has adequate large muscle coordination? ___ Yes ___ No

h. Do you notice, or has a doctor reported, any of the following in this child?

- | | | |
|--|---|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Nose Bleeding | <input type="checkbox"/> Frequent Fevers |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Epilepsy (seizures) |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Bed Soiling | <input type="checkbox"/> Overtired/Lacking Pep |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Serious blows to head |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Thumb Sucking | <input type="checkbox"/> Lack of Consciousness |
| <input type="checkbox"/> Nail Biting | <input type="checkbox"/> Chronic Ear Infections | |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Chronic Stomach Problems | |
| <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Medical Problems Immediately After Birth | |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Allergies (types) _____ | |

5. Please check (✓) Yes, Sometimes, No, or Not sure for each of the following statements:

a. It is my (our) opinion that this child:

	<u>YES</u>	<u>SOMETIME</u>	<u>NO</u>	<u>NOT SURE</u>
Should have regular playmates the same age	_____	_____	_____	_____
Has difficulty getting along with other children	_____	_____	_____	_____
Prefers to play with other children instead of alone	_____	_____	_____	_____
Is difficult to understand when talking	_____	_____	_____	_____
Seems generally happy	_____	_____	_____	_____
Is frequently irritable or moody	_____	_____	_____	_____
Is upset by changes in routine	_____	_____	_____	_____
Demands much individual adult attention	_____	_____	_____	_____
Accepts discipline and limits	_____	_____	_____	_____
Becomes confused in following more than two Verbal directions at a time	_____	_____	_____	_____
Has difficulty remembering things for a short time	_____	_____	_____	_____
Has difficulty remembering things for a long time	_____	_____	_____	_____
Is easily frustrated	_____	_____	_____	_____
Cries easily	_____	_____	_____	_____
Cooperates willingly	_____	_____	_____	_____
Has a bad temper	_____	_____	_____	_____
Can use a fork and spoon without help	_____	_____	_____	_____
Can catch a ball thrown to him	_____	_____	_____	_____
Enjoys physical activities	_____	_____	_____	_____
Loses balance, trips and falls	_____	_____	_____	_____
Is dealing with family stress such as illness, death? or separation	_____	_____	_____	_____

b. How old are this child's playmates? _____

c. About how many hours a day does your child watch TV? _____

d. What kinds of things do you like to do with your child? _____

e. Do you have any special concerns about this child? _____

f. Is your child toilet trained? _____

- g. Is there any other information that will help us better understand this child? _____

- h. Other physical problems or serious illnesses? (explain) _____

- i. Child's birth weights _____ lbs. _____ ozs.
- j. Special Considerations:
 _____ Caesarean _____ Child Rotated _____ Premature
 _____ Cord Around Neck _____ Breech _____ Twin (1st/2nd born)
 _____ Baby Blue _____ Baby Yellow _____ Baby Bruised
 _____ R.H. Negative _____ Transfused
- k. Special Care:
 _____ Oxygen (how long) _____
 _____ Incubator, (how long) _____
 _____ Hospital Stay (how long) _____
 _____ Seizures or loss of consciousness? _____
 _____ Is this child presently on medication? _____ What? _____
- l. Has child had any significant injuries or hospitalization? _____

- m. Is this child prone to certain ailments? (e.g. ear infections, stomach aches, etc?) _____

- n. Has your child ever been referred for Special Education needs.... Past or present? _____

6. Do you participate in any of the following programs (Please check)?

- _____ Social Security _____ Medicaid _____ Welfare
 _____ Aid for Dependent Children (AFDC)

Thank you for your cooperation in filling out this questionnaire.

Name: _____

Date: _____