Early Childhood Learning Center

Form F *Where 'Little' is Great!*

Health and Development Questionnaire

The information collected in this document is designed to assist us in understanding your child's specific needs and in developing an appropriate educational program for him/her. It is important that you answer all the questions as honestly and accurately as possible. If you do not know the answer to a question please put a question mark in the space.

Child's Full Name: _____ Nickname: _____

Date of Birth: _____ Gender: M F Home Phone: _____

Cell Phone: _____ Work Phone: _____ Email Address: _____

Home Address: _____

Child's first spoken language: _____ Language **child** uses at home: _____

Language **parent** uses to speak to child: _____ Language **adults** use at home: _____

Parent's primary language: _____ Do **parents** require an interpreter? Yes No

Does **child** require an interpreter? Yes No Is the **child** Hispanic or Latino? Yes No

Child's race: American Indian/Alaskan Native Asian Black/African American Native Hawaiian/Pacific Islander White

If multilingual, what percentage of time does your **child** use English? 10% 30% 50% 70% 90%

Family Information

1. Mother's Name: _____DOB:_____ Lives with child? Yes No

Please check one box:

☐ Biological Mother ☐ Foster Mother ☐ Adopted ☐ Other: _____

☐ Married ☐ Divorced ☐ Separated ☐ Unmarried

Highest level of schooling completed? ☐ High school ☐ College ☐ Graduate Studies

Occupation: _____ Employed? ☐ Yes/Where: _____ ☐ No

History of drug use, alcohol abuse or criminal conviction? ☐ Yes ☐ No If yes, explain:

_____

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Any past or current family, educational, social, psychological or medical issues/problems/changes?
☐ Yes ☐ No If yes, explain: _____

_____

2. Father's Name: _____DOB:_____ Lives with child? Yes No
Please check one box:
☐ Biological Father ☐ Foster Father ☐ Adopted ☐ Other: _____

☐ Married ☐ Divorced ☐ Separated ☐ Unmarried

Highest level of schooling completed? ☐ High school ☐ College ☐ Graduate Studies

Occupation: _____ Employed? ☐ Yes/Where: _____ ☐ No

History of drug use, alcohol abuse or criminal conviction? ☐ Yes ☐ No If yes, explain:

_____

Any past or current family, educational, social, psychological or medical issues/problems/changes?
☐ Yes ☐ No If yes, explain: _____

_____

3. Other Individuals living with or caring for the child; their birthdate and relationship (e.g., sibling, extended family, care-giver, etc.)

Name	Date of Birth	Relation to child	Living with?	Caring for?

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4. Has the child ever lived away from their immediate family? ☐ Yes ☐ No Explain: _____

_____

5. Any immediate or extended family members with history of developmental disabilities, delays or concerns (please specify relation to child and disability, delay or concern)? _____

_____

_____

Pregnancy/Delivery Information

1. Mother's total number of pregnancies: _____ Mother's age during this pregnancy? _____ # of Living children? _____
2. Relationship with father during pregnancy: ☐ Married ☐ Divorced ☐ Dating ☐ No Relationship
3. Was there prenatal care during the pregnancy? ☐ Yes ☐ No If yes, what month did it begin? _____
4. Did the mother have any health problems during the pregnancy (illness, infections, etc.)? ☐ Yes ☐ No
   If yes, explain: _____
5. Did the mother take any medication (Aspirin, antibiotics, etc.) or hormones (birth control, etc.) during pregnancy?
   ☐ Yes ☐ No If yes, explain: _____
6. Did the mother smoke, use drugs or consume alcohol at any time during the pregnancy? .)? ☐ Yes ☐ No
   If yes, explain: _____
7. Did the mother experience any noteworthy stress during the pregnancy (e.g., marital, job, family, financial, physical, emotional)? ☐ Yes ☐ No If yes, explain: _____
8. How long was the pregnancy (in weeks)? _____ Was labor: ☐ Spontaneous ☐ Induced
   Any medication given? ☐ Yes ☐ No If yes, explain: _____
9. Length of labor in hours? _____ Type of delivery: ☐ Breech ☐ Vaginal ☐ Caesarean ☐ Forceps
   If breech, Caesarean or forceps, please briefly explain why: _____
10. Weight at birth: _____ Length at birth: _____ Apgar Scores: 1 minute _____ 5 minutes _____
11. Any complications/problems during labor or delivery (cord around neck, hemorrhaging, injuries)? ☐ Yes ☐ No
    If yes, explain: _____ (include epidural, anesthesia, or meds)

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12. Number of days baby was in the hospital? _____ Number of days mother was in hospital? _____
13. Did baby or mother have any conditions, infections or problems after birth? _____

_____

Infancy and Early Childhood Information

Medical History: Please check mark 'Yes' or 'No' and when appropriate, provide dates/comments/explanation

	Yes	No	Frequency	Dates/comments
Pneumonia				
Asthma				
Rashes				
Fractures				
Stitches				
Febrile Convulsions				
High Fevers				
Seizures				
Head Injury				
Unconscious Periods				
Emergency Room Visits				
Serious Accident				
Surgery				
Hospitalization				
Allergies				
Food/Diet/Restrictions				
Colic				
Medications	Dosage		Frequency	Comments

Hearing/Vision History:

	Yes	No	If Yes, date & outcome
Has your child had a vision exam?			
Current vision concerns?			Glasses?
Has your child had a hearing exam?			

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	Yes	No	
Current hearing concerns?			Hearing aids?
Has your child had a history of ear infections?			Frequency?
Has your child had tubes inserted in ears?			Date

Date of last ***medical*** exam? _____ Date of last ***dental*** exam? _____

Developmental Milestones ~ Provide the approximate age in months/years the child accomplished this:

Rolled over:	Smiled in response to people:
Sat alone:	First single word(s):
Crawled:	Two-word phrases:
Walked alone:	Three-word phrases:
Dressed self:	# of words per utterance:
Ate solid food:	# of words in your child's vocabulary:
Fed self with fork/spoon:	% of speech intelligible to others:
Toilet trained day:	Toilet trained night:
Sleep through the night:	Sleep through night began at:
Concerns about feeding/eating habits? If yes, explain:	

Does your child:	Yes	No
Use a pacifier		
Suck his/her thumb		
Sleep in parent's bed		

Has your child been formally diagnosed with a condition or disability (e.g., Cerebral Palsy, Down Syndrome, Autism, etc.)? ☐ Yes ☐ No If yes, please specify by whom, what, and when: _____

_____

Child Development: Parental Perceptions and Concerns

1. Do you have any concerns about your child's **communication** (speech or language) skills? ☐ Yes ☐ No

   If yes, explain: _____

2. Do you have any concerns about your child's **motor skills** (gross or fine)? ☐ Yes ☐ No

   If yes, explain: _____

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3. Do you have any concerns about your child's **cognitive/reasoning or pre-academic skills**? ☐ Yes ☐ No

   If yes, explain: _____

4. Do you have any concerns about your child's **behavior**? ☐ Yes ☐ No

   If yes, explain: _____

5. Do you have any concerns about your child's **social-emotional or play skills**? ☐ Yes ☐ No

   If yes, explain: _____

6. What types of discipline or consequences does the child experience in the home (verbal reprimands, time outs, removal of privileges, rewards, physical punishment, giving in to child, avoiding child, redirecting child, etc.)? Please specify below the common reason, method and response to discipline:

Common Reason Child is Disciplined	Method of Discipline	Child's Response to Discipline

7. Please list your child's favorite activities, foods, games, books and toys: _____

_____

_____

8. Any significant or noteworthy events or experiences in your child's or family's life? _____

_____

9. Please check 'yes' or 'no' to each question: Does your child . . .

	Yes	No
cuddle like other children?		
look at you when you are talking or playing?		
smile in response to a smile from others?		
engage in reciprocal, back-and-forth play?		
play simple imitation games (e.g., pat-a-cake or peek-a-boo)?		
show interest in other children?		
point with his/her finger?		
gesture (e.g., nod yes and no)?		

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	Yes	No
direct your attention by holding up objects for you to see?		
show things to people?		
give consistent response to their name or commands?		
use rote, repetitive or echolalic speech?		
memorize strings of words or scripts?		
have repetitive, stereotyped or odd motor behavior?		
have preoccupations or a narrow range of interests?		
attend more to parts of an object instead of the whole object (e.g., the wheels of a toy car)?		
have limited or absent pretend play?		
imitate other people's actions?		
play with toys in the same exact way every time?		
appear strongly attached to a specific unusual object(s)?		
Has your child's development ever appeared to regress? If yes, please explain:		

10. How would you describe your child's temperament/behavior (check all that apply)?

___happy ___difficult ___easy ___friendly ___hyper ___impulsive ___inattentive ___ kind

___social ___defiant ___in own world ___withdrawn Other: _____

11. Does your child relate ***well*** to all family members? ☐ Yes ☐ No

If **no**, explain: _____

12. Any safety concerns/restrictions for your child playing on preschool playground equipment? ☐ Yes ☐ No

If yes, explain: _____

13. Please note below any other safety or health concerns you have for your child: _____

_____

14. Sensory Development:

Please check 'yes' or 'no' to each question:

Auditory System: Is your child . . .	Yes	No
Bothered by any household or ordinary sounds (e.g., vacuum, dryer, toilet, etc.)?		
Distracted by sounds not usually noticed by other people?		
Easily distracted by irrelevant noises (e.g., lawn mower outside, air conditioner, lights, etc.)		
Overly sensitive to sounds?		
If any checked yes, please explain:		

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	Yes	No
Gustatory/Olfactory System: Does your child . . .		
Have strong preferences for certain food textures?		
Gag or vomit on certain food textures?		
If any checked yes, please explain:		
Proprioception System: Does your child seem . . .		
Driven to seek activities such as pushing, pulling, dragging, lifting, jumping?		
Unsure of how far to raise/lower the body (e.g., when sitting down, stepping over)?		
To exert too much pressure for the task (e.g., slamming doors, pressing too hard)?		
To bump or push other children		
Chew on toys, clothes or other objects more than other children?		
If any checked yes, please explain:		
Tactile System: Does your child . . .		
Pull away from being touched lightly?		
Struggle against being held?		
Have a tendency to touch things constantly?		
Seem bothered by having his/her face washed or teeth brushed?		
Avoid getting his/her hands in finger paint, glue, sand, clay or other messy things?		
If any checked yes, please explain:		
Vestibular System: Does your child . . .		
Demonstrate distress when he/she is moved or riding on moving equipment?		
Like fast spinning carnival rides, such as merry-go-rounds?		
Seem to not get dizzy when others usually do?		
Rock himself/herself when stressed?		
If any checked yes, please explain:		
Does your child have any unusual sensory sensitivities or fears? If any checked yes, please explain:		

Preschool and Early Intervention Background Information

1. Has your child recently/currently attended a preschool and/or daycare? ☐ Yes ☐ No

Name of current preschool/daycare: _____

Teacher/Staff name(s): _____ Phone #:_____

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Dates attended: _____ Days and times attended: _____

How do you feel your child is performing in preschool/daycare? ___poor ___average ___above average

Please list any concerns regarding your child's functioning at preschool/daycare: _____

_____

2. Has your child attended other preschools/daycares? ☐ Yes ☐ No

Name of current preschool/daycare: _____

Teacher/Staff name(s): _____ Phone #:_____

Dates attended: _____ Days and times attended: _____ Reason for leaving: _____

3. Is your child currently a client of Regional Center? ☐ Yes ☐ No If yes, date eligible:_____

Service Coordinator's Name(s) & Phone #: _____

4. Have you participated in parenting classes? ☐ Yes ☐ No If yes, list name of class and when:

_____

5. Has the child received any assessments or services in the following areas? If so, please provide copies of the reports.

Speech and Language: ☐ Yes ☐ No Agency/Therapist Name: _____ Date attended:_____

Behavioral/Psychological: ☐ Yes ☐ No Agency/Therapist Name: _____ Date attended:_____

Occupational/Physical: ☐ Yes ☐ No Agency/Therapist Name: _____ Date attended:_____

Neurology: ☐ Yes ☐ No Agency/Therapist Name: _____ Date attended:_____

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Parental Perceptions and Goals for Their Child

1. Please describe where and how often your child interacts with other children (e.g., weekly at park, daily at daycare, twice per week in speech therapy, daily with siblings/friends at home)?

2. How does your child interact/play with other children? Please check all that apply:

☐ usually ignores them ☐ imitates them ☐ plays near/parallel to them ☐ interacts with them ☐ observes only

How would you describe your child's interactions and relationships with peers?

3. Please state any specific goals or skills that you would like your child to achieve in the next year (e.g., speak more clearly, expand expressive vocabulary, learn to match objects, improve fine motor skills, etc.):

4. Please describe your ideal preschool environment for your child (if you have a specific preschool you are interested in sending your child to, please note that as well):

5. Please note anything else you would like the Early Childhood Learning Center to consider when assessing your child, developing an education program for him/her and/or providing special education services:

Signature of person completing this form: _____ Date: _____

Relation to Child: _____

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