

# THE CHILDREN'S CENTER

## PARENT/CAREGIVER QUESTIONNAIRE

Please take a few minutes to complete the following information about your child.

Date: \_\_\_\_\_

Name of Child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Person completing this form: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

### DEVELOPMENTAL HISTORY

Duration of pregnancy:  Full term  Premature  Post term

Complications during pregnancy?  Yes  No  History unknown

Type of delivery:  vaginal  c-section  breech  induced  forceps

Child's birth weight: \_\_\_\_\_ pounds \_\_\_\_\_ ounces

Complications during delivery?  Yes  No  History unknown

Was there any fetal distress during the delivery?  Yes  No  Don't know

Did the child require a stay in Newborn Intensive Care?  No  Yes

(how long?) \_\_\_\_\_ (reason?) \_\_\_\_\_

Difficulty feeding or sucking?  Yes  No Neonatal jaundice?  Yes  No

Needed respiratory assistance?  Yes  No Other complications?  Yes  No

Was baby breast fed?  Yes  No

Did mother experience post-partum depression?  Yes  No

If yes, for how long? \_\_\_\_\_

#### Infant was: (check all that apply)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Usually easy to feed     | <input type="checkbox"/> Usually difficult to feed    | <input type="checkbox"/> Usually easy going |
| <input type="checkbox"/> Often fussy or irritable | <input type="checkbox"/> Liked to be held and cuddled | <input type="checkbox"/> Was hard to hold   |
| <input type="checkbox"/> Good sleeper             | <input type="checkbox"/> Difficulty sleeping          | <input type="checkbox"/> Played peek-a-boo  |
| <input type="checkbox"/> Happy and content        | <input type="checkbox"/> Sad                          | <input type="checkbox"/> Cried a lot        |

Primary caregiver:  returned to work when the child was age: \_\_\_\_\_  
 Full time  Part time  
 still home with child.

**MEDICAL HISTORY OF CHILD**

**How is your child's general health?**  Very good  Fair  Poor

**Is your child currently taking any medications?**  Yes  No

Please list:

**Does your child have any allergies?**  Yes  No

- Medication allergy** (describe): \_\_\_\_\_  
 **Food allergy** (describe): \_\_\_\_\_  
 **Other allergy** (describe): \_\_\_\_\_

**Do you have any concerns about possible hearing loss?**  Yes  No

**Does your child have a history of chronic or frequent ear infections?**  Yes  No

**Were PE tubes placed in the child's ears?**  Yes  No

**Has your child had a hearing screening?**  Yes  No

**Has your child had a vision screening?**  Yes  No

**Does your child have any of the following chronic health problems?**  Yes  No

- |   |   |
|---|---|
| <input type="checkbox"/> <b>Asthma</b>          | <input type="checkbox"/> <b>Diabetes</b>          |
| <input type="checkbox"/> <b>Heart Condition</b> | <input type="checkbox"/> <b>Seizure Disorder</b>  |
| <input type="checkbox"/> <b>Kidney Problems</b> | <input type="checkbox"/> <b>Failure to Thrive</b> |
| <input type="checkbox"/> <b>HIV</b>             | <input type="checkbox"/> <b>Other</b> _____       |

**Has your child had any accidents resulting in the following:**  Yes  No

- Broken bones**  
 **Head injury**  
 **Stitches**  
 **Poisoning**  
 **Serious burns**

**DEVELOPMENTAL MILESTONES****Motor Development**

Child began to walk at the age of \_\_\_\_\_ months.

Can your child pedal a tricycle?  Yes  No  Not old enough

Can your child put simple puzzles together?  Yes  No  Not old enough

Can your child color?  Yes  No  Not old enough

Can your child cut with scissors?  Yes  No  Not old enough

*Have you had any concerns about your child's coordination?*  Yes  No

**Language Development**

Child began to use single words (other than mamma/dadda) at the age of \_\_\_\_\_ months.

Child began to use two-word sentences at the age of \_\_\_\_\_ months.

Child currently does not use single words.

Child currently does not use 2-word sentences.

*Have you had any concerns about your child's speech skills?*  Yes  No

**Self-Care Skills**

Is your child able to dress independently?  Yes  No  Not old enough

Is your child able to feed himself/herself?  Yes  No  Not old enough

*Have you had any concerns about your child's self-care skills?*  Yes  No

**Toilet Training**

Does your child have problems with wetting?  Yes  No  Still in diapers

Does your child have problems with soiling?  Yes  No  Still in diapers

*Do you have any concerns about toilet training your child?*  Yes  No

**CHILD CARE/PRESCHOOL/SCHOOL PLACEMENT**

Child has never been in either daycare or preschool.

Child currently attends daycare or preschool at

(name of agency): \_\_\_\_\_

Teacher(s): \_\_\_\_\_

Days/times: \_\_\_\_\_

Has your child's teacher had concerns about any of the following behaviors:

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Separation Problems     | <input type="checkbox"/> Aggression      | <input type="checkbox"/> Opposition    | <input type="checkbox"/> Tantrums         |
| <input type="checkbox"/> Poor peer relationships | <input type="checkbox"/> Distractibility | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Impulsiveness    |
| <input type="checkbox"/> Destructive behavior    | <input type="checkbox"/> Anxiety         | <input type="checkbox"/> Clinginess    | <input type="checkbox"/> Excessive crying |
| <input type="checkbox"/> Learning problems       | <input type="checkbox"/> Other _____     |  |   |

**PREVIOUS DAYCARE OR PRESCHOOL PLACEMENTS**

Agency or Individual	Entered at age	Left at age	Concerns

**FAMILY PSYCHIATRIC HISTORY**

Does anyone on the mother's side of the family have:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Drug Addictions               | <input type="checkbox"/> Alcoholism     | <input type="checkbox"/> Depression    |
| <input type="checkbox"/> Obsessive Compulsive Disorder | <input type="checkbox"/> Severe Anxiety | <input type="checkbox"/> Hyperactivity |
| <input type="checkbox"/> Learning Problems             | <input type="checkbox"/> Schizophrenia  | <input type="checkbox"/> Autism        |
| <input type="checkbox"/> Bipolar Disorder              | <input type="checkbox"/> Unknown        |  |
| <input type="checkbox"/> Other _____                   |   |  |

Does anyone on the father's side of the family have:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Drug Addictions               | <input type="checkbox"/> Alcoholism     | <input type="checkbox"/> Depression    |
| <input type="checkbox"/> Obsessive Compulsive Disorder | <input type="checkbox"/> Severe Anxiety | <input type="checkbox"/> Hyperactivity |
| <input type="checkbox"/> Learning Problems             | <input type="checkbox"/> Schizophrenia  | <input type="checkbox"/> Autism        |
| <input type="checkbox"/> Bipolar Disorder              | <input type="checkbox"/> Unknown        |  |
| <input type="checkbox"/> Other _____                   |   |  |