



Park Nicollet

Park Nicollet Alexander Center

NAME:

DOB:

MR#:

HCL# :

LABEL or ADDRESSOGRAPH

Early Childhood Questionnaire

Child's name	Child's date of birth	Child's age
Form completed by		Date form completed

FAMILY INFORMATION

Parent

Name	
Street address	
City, State, ZIP	
Home phone	Work phone
Education	Occupation

Parent

Name	
Street address	
City, State, ZIP	
Home phone	Work phone
Education	Occupation

Family status:

Married Separated (in _____ / _____) Divorced (in _____ / _____) Never married

Does your child have stepparents? No Yes. If yes, please complete below:

Stepparent

Name	
Street address	
City, State, ZIP	
Home phone	Work phone
Education	Occupation

Stepparent

Name	
Street address	
City, State, ZIP	
Home phone	Work phone
Education	Occupation

Is your child adopted? No Yes. If yes, how old was the child at time of adoption? _____

Is your child aware of the adoption? No Yes

If separated, child's primary residence is with whom? _____

Name of child's legal guardian _____

Name of child's foster parents _____

Foster parents' address _____

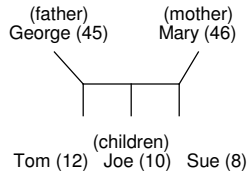
PRESCHOOL INFORMATION

School name	Homeroom teacher	Grade
Address		
Contact person	Phone	Fax

please complete the reverse side

SOCIAL HISTORY

Please draw the family constellation at the child's primary residence and at the residence of the child's other parent (if living separately). Include ages of all children and adults living in the home. Use the following illustration as an example.



1. Yes No Have other adults or children lived in the home currently or in the past? If yes, what is their relationship with your child?

2. Yes No Has your child experienced any parental separations or the death of any family member? If yes, please describe circumstances (for example, child's age or event)

3. Yes No Is either parent away from home for several days at a time on a regular basis?
4. Yes No Does your cultural heritage play a significant role in your daily life?
5. If parents are divorced/separated, how often does the child visit with the other parent? _____

SIBLINGS

Name	Age	Relationship to child	Where living?

FAMILY MEDICAL HISTORY

Please indicate all medical conditions that have occurred in the child's biological relatives. Indicate which relative in the space provided. Under sibling, indicate sister (S) or brother (B). For all other relatives, indicate which side of the family, mother (M) or father (F). For example, if the child's mother's sister has a learning disability, you would place an "M" in the box under "Aunt" in the column labeled "learning disability."

	Mother	Father	Sibling	Aunt	Uncle	Cousin	Grandparent	Other
Learning disability								
Attention deficit disorder								
Mental retardation								
Autism								
Pervasive development disorder								
Speech and language disorder								
Hearing loss/deafness								
Tourette's or tic disorder								
Congenital disorder								
Thyroid disease								
Chronic illness (please list: _____ such as asthma, arthritis, diabetes, lupus)								
Depression								
Manic/depressive (bipolar)								
Suicide attempt								
Anxiety								
Obsessive compulsive disorder								
Schizophrenia								
Psychiatric hospitalization								
Alcohol dependency								
Chemical dependency								
Other								

Yes No Has anyone in the child's family (mother, sibling, father) ever received psychological assessment, treatment or hospitalization, including for drug and alcohol abuse? If yes, please explain.

Family member	Age	Clinician or facility	Reason for treatment
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SPACE BELOW RESERVED FOR INTAKE INTERVIEWER

Number	Mother's family	Number	Father's family
Number	Mother's family	Number	Father's family

CHILD'S MEDICAL HISTORY

PREGNANCY

- Yes No The pregnancy was mother's _____ of _____ pregnancies with _____ live births.
(number) (number) (number)
- Yes No Did any of the following occur before the pregnancy?
 Fertility medications Miscarriages
- Yes No Did any of the following occur during the pregnancy?
 Maternal injury, describe: _____
 Infections, describe: _____
 Excessive vomiting
 Abnormal weight gain
 Poor weight gain
 Measles
 Toxemia
 Gestational diabetes
 Anemia
 Measles
 Exposure to toxins
 Hypertension
 X-rays, which months: _____
 Bleeding, spotting, which months: _____
 Abnormal emotional stress (such as work hours, death of a relative)
 Prenatal testing (such as CMV, HIV, TORCH)
 Don't know
 Alcohol use: amount per day: _____
 Cigarette use: amount per day: _____
 Medication use: describe, which months: _____
 Drugs (such as cocaine, marijuana), which months: _____
- Yes No Did any of the following complications occur during labor or delivery?
 Labor induced Cesarean delivery
 General anesthesia Breech delivery
 Fetal distress Forceps delivery
 Prolonged labor, _____ hours Multiple birth
 Other _____

9. Yes No Is your child currently seeing any medical specialists or therapists (such as neurology, occupational therapy or physical therapy)? If yes, provide name.
- _____
- _____
- _____
10. Yes No Does your child experience any of the following difficulties with sleep?
- Difficulty falling asleep Waking in the night Nightmares Early morning waking
- Night terrors Sleeps too much Snoring Apnea
- Falls asleep during day (other than age-appropriate naps)
- Other _____
11. Yes No Does your child have any of the following difficulties with eating?
- Difficulty sitting at the table Overeats Avoids foods due to texture
- Poor food choices Picky eater Odd eating behavior/habits
- Other _____
12. Yes No Does your child have any of the following difficulties with elimination?
- Daytime wetting Toilet refusal Night wetting
- Constipation Soiling Diarrhea
- Other _____
13. Yes No Does your child frequently complain of physical symptoms not related to a medical problem?
- Stomachaches Headaches Joint aches
- Fatigue Dizziness Heart palpitations
- Breathing problems Tremors/shakes
- Other _____
14. Which hand does your child use to complete tasks?
- Right Left Both
15. Yes No Does your child have problems with coordination?
- Large motor coordination
- Small motor coordination (handwriting, cutting, sipping ...)
16. Yes No Does your child display any unusual repetitive movements or noises (tics)?
- Head, facial or neck twitches
- Nervous habits, describe _____
- Repetitive actions when excited, describe _____
- Problems with balance
- Walks in unusual manner
- Walks on tiptoes
- Is generally clumsy
- Other _____
17. Yes No Does your child act in any of the following ways?
- Frequently seems unaware of others in the room, fails to react to noise
- Echoes or repeats words or phrases over and over
- High pain tolerance
- Repeats same behavior
- Becomes agitated if not permitted to perform ritual or routine behavior
- Sensory sensitivities (such as textures of food, smells, upset by bright lights, excessive reaction to noise, overreaction to touch)
- Seems unafraid of dangerous activity (such as shows no fear when on high playground equipment)
- Speaks using sing-song or high pitched intonation
18. Yes No Does your child have a history of any of the following?
- Depression Chemical abuse Don't know
- Mood swings Alcohol abuse
- Suicidal thoughts/attempts Unusual thinking
- Physical abuse Anxiety
- Sexual abuse

19. Yes No Does your child have any problems getting along with others?
- Few friends/loner Difficulty making friends Competitive with siblings
- No best friend Difficulty keeping friends Plays mainly with younger children
- Not respectful of authority Plays mainly with older children

20. Please describe your child's personality (such as sensitive, happy, compassionate, stubborn, angry, easygoing, bubbly)

21. What do you enjoy most about raising your child?

22. What are your child's main strengths?

23. What are your child's main weaknesses?

BIRTH

1. Mother's age at time of delivery _____ Father's age _____

2. Hospital, city and state of birth

3. Length of pregnancy _____ weeks (if an infant is born on his due date, the pregnancy is 40 weeks long)

4. What was the child's weight at birth? _____ lbs. _____ ozs.

5. Apgar scores _____ 1 minute _____ 5 minutes

6. Child's condition at birth?

- Excellent Good Fair Poor Don't know

7. Length of hospital stay:

Infant _____ Mother _____

PERINATAL HEALTH

8. Yes No Did any of the following complications occur after delivery?

- Infection/fever
- Incubator How long? _____
- Jaundiced
- Breathing problems
- Respirator How long? _____
- Bleeding in the brain
- Difficulty sucking/feeding
- Heart problems

9. Yes No Were there any congenital defects/anomalies (such as cleft palate)?

DEVELOPMENTAL HISTORY

1. Please describe your child's temperament at the following ages:
- | | | | | |
|----------------------------|---|--------------------------------|----------------------------------|--------------------------------------|
| Infancy (birth to 12 mos.) | <input type="checkbox"/> Pleasant/happy | <input type="checkbox"/> Fussy | <input type="checkbox"/> Colicky | <input type="checkbox"/> Other _____ |
| Toddler (13 to 36 mos.) | <input type="checkbox"/> Pleasant/happy | <input type="checkbox"/> Fussy | <input type="checkbox"/> Colicky | <input type="checkbox"/> Other _____ |
| Preschool (36 to 60 mos.) | <input type="checkbox"/> Pleasant/happy | <input type="checkbox"/> Fussy | <input type="checkbox"/> Colicky | <input type="checkbox"/> Other _____ |
2. Was there anything unusual about how your child developed (didn't like to be held, very early interest in numbers ...)?
- _____
- _____

BIRTH TO ONE YEAR

1. Yes No In the first year, did your infant experience any of the following?
- | | |
|--|--|
| <input type="checkbox"/> Breathing problems | <input type="checkbox"/> Ear infections |
| <input type="checkbox"/> Feeding problems | <input type="checkbox"/> Injury |
| <input type="checkbox"/> Weight loss or poor weight gain | <input type="checkbox"/> Developmental delay |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Other infections |
| <input type="checkbox"/> Sleep problems | |

ONE TO THREE YEARS

1. Yes No From age one to three, did any of the following occur?
- | | |
|--|---|
| <input type="checkbox"/> Excessive temper tantrums | <input type="checkbox"/> Recurrent ear infections |
| <input type="checkbox"/> Developmental delay | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Ear tubes inserted | <input type="checkbox"/> Behavior problems |
| <input type="checkbox"/> Separation problems | |

THREE TO FIVE YEARS

1. Yes No From age three to five, did any of the following occur?
- | | |
|--|---|
| <input type="checkbox"/> Excessive temper tantrums | <input type="checkbox"/> Recurrent ear infections |
| <input type="checkbox"/> Developmental delay | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Separation problems | <input type="checkbox"/> Behavior problems |
| <input type="checkbox"/> Toileting problems | <input type="checkbox"/> Ear tubes inserted |
| <input type="checkbox"/> Difficulty with structured activity | <input type="checkbox"/> High activity level |
| <input type="checkbox"/> Difficulty with transitions | <input type="checkbox"/> Short attention span |
2. Yes No Did preschool teachers, day-care providers or other caregivers observe difficulty with any of the following?
- | | |
|--|---|
| <input type="checkbox"/> Structured activity | <input type="checkbox"/> Group activity |
| <input type="checkbox"/> Behavior | <input type="checkbox"/> Attention |
| <input type="checkbox"/> Peer relationships | <input type="checkbox"/> Transitions |

DEVELOPMENTAL MILESTONES

1. At what age did your child first do the following? Please indicate age in months (such as 16 mos.)
- | | | |
|-------------------|----------------------------|---|
| _____ Turn over | _____ Feed self with spoon | _____ Speak first words |
| _____ Sit alone | _____ Tie shoes | _____ Use two-word to three-word combinations |
| _____ Crawl | _____ Bowel trained | _____ Begin to read |
| _____ Walk alone | _____ Bladder trained | _____ Write name |
| _____ Ride a bike | _____ Dry at night | |
2. Has your child shown any loss of previous abilities (such as he was speaking in two-word sentences, then stopped talking or began using one word only). Please describe.
- _____
- _____
- _____
3. Yes No Has your child ever been diagnosed with a behavior or emotional problem? If yes, please complete below.
- | Diagnosis | Age | Clinician or facility | Treatment |
|-----------|-------|-----------------------|-----------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

7. Yes No Has your child been involved in any of the following educational programs?
- | | |
|--|---|
| <input type="checkbox"/> Early Childhood Special Ed. | <input type="checkbox"/> Autism services |
| <input type="checkbox"/> Title 1 or Chapter 1 | <input type="checkbox"/> Friendship group/social skills group |
| <input type="checkbox"/> Assurance of Mastery–Reading | <input type="checkbox"/> Counseling |
| <input type="checkbox"/> Assurance of Mastery–Math | <input type="checkbox"/> Mental retardation/mental impairment |
| <input type="checkbox"/> Learning disabilities program | <input type="checkbox"/> Home tutoring |
| <input type="checkbox"/> Emotional/behavioral disorder program | <input type="checkbox"/> Private tutoring |
| <input type="checkbox"/> Program for other health-impairment | <input type="checkbox"/> Homebound instruction |
| <input type="checkbox"/> Speech-language therapy | <input type="checkbox"/> Gifted and talented programming |
| <input type="checkbox"/> Occupational therapy | <input type="checkbox"/> Multiple handicaps |
| <input type="checkbox"/> Physical therapy | <input type="checkbox"/> I don't know the program's name |

8. Yes No Currently or in the past, has your child's teacher discussed any of these problems?
- | | |
|--|---|
| <input type="checkbox"/> Getting along with peers | <input type="checkbox"/> Turning in assigned work |
| <input type="checkbox"/> Disrupting classroom | <input type="checkbox"/> Rushing to complete work |
| <input type="checkbox"/> Getting along with teachers | <input type="checkbox"/> Staying on task during work periods |
| <input type="checkbox"/> Difficulty waiting turn | <input type="checkbox"/> Making frequent careless errors |
| <input type="checkbox"/> Excessive socializing | <input type="checkbox"/> Completing large or long-term projects |
| <input type="checkbox"/> Following rules (classrooms, bus, recess, lunch) | <input type="checkbox"/> Organization of work materials |
| <input type="checkbox"/> Completing work on time | |
| <input type="checkbox"/> Following directions | |
| <input type="checkbox"/> Forgetting to bring homework materials home or to return completed work | |

9. Yes No Has your child ever experienced any of the following?
- Delayed kindergarten entry
- Retained in grade _____
- In-school suspension, reason _____ in grade _____
- Suspended for _____ days, reason _____ in grade _____
- Expelled, reason _____ in grade _____

SPEECH AND LANGUAGE HISTORY

1. Yes No Do you have any current concerns about your child's speech or language?
2. Yes No Is your child currently receiving speech or language therapy?
3. Yes No Does your child have a history of speech or language problems?
4. Yes No Has your child received speech therapy in the past? If yes, please complete the following
- | | |
|--|---------------------------|
| Nature of problem (language delay ...) | Dates of service/facility |
| _____ | _____ |
5. Yes No Does your child have a current IEP/IFSP in speech or language? If yes, which of the following services are included.
- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> Expressive language | <input type="checkbox"/> Voice therapy | <input type="checkbox"/> Articulation |
| <input type="checkbox"/> Receptive language | <input type="checkbox"/> Fluency (such as stuttering) | |
| <input type="checkbox"/> Other _____ | | |

RECEPTIVE / EXPRESSIVE LANGUAGE

1. Yes No Does your child have any of the following problems understanding language?
- | | |
|---|---|
| <input type="checkbox"/> Following single-part directions | <input type="checkbox"/> Understanding age-appropriate jokes |
| <input type="checkbox"/> Following multipart directions | <input type="checkbox"/> Understanding idioms (such as "You missed the boat") |
| <input type="checkbox"/> Understanding questions | <input type="checkbox"/> Understanding vocabulary |
2. Yes No Does your child have any problems with expressive language?
- | | |
|--|--|
| <input type="checkbox"/> Grammar/syntax | <input type="checkbox"/> Initiating conversation |
| <input type="checkbox"/> Maintaining topic of conversation | <input type="checkbox"/> Adjusting to listener's needs |
| <input type="checkbox"/> Sequencing story from start to finish | <input type="checkbox"/> Using appropriate vocabulary |
| <input type="checkbox"/> Other _____ | |

ARTICULATION

1. Yes No Does your child have any problems saying sounds correctly?
- Specific sound errors, describe _____
- Difficulty sequencing long words

Please attach a picture of your child in the space below

Thank you very much for completing this questionnaire. This information will help us evaluate your child.

Please return this form to:

Park Nicollet Alexander Center
M & I Bank Building
11455 Viking Drive
Eden Prairie, MN 55344