Completed by: ______________________________ Date:________________________________

RUTLAND CITY PUBLIC SCHOOLS
CHILD FIND
DEVELOPMENTAL QUESTIONNAIRE

Child's name: ____

Birth date: _____________________ Age: ___________________

Address: _______________________ City: _________________ State: _____ Zip: _____________

Is this your mailing address? Y/N ______ If no: ____

How long at your current address? __________________ Phone #:_____________________________

Residence history: ____

Primary language spoken at home: _______________________________

- -

Biological father's name: ____

Biological mother's name: ____

Are, or were, parents married? Y/N ____ date _________________ Step-parents? Y/N _____

Separated? Y/N ____ date ________________ Divorced? Y/N ____ date ____________________

If separated or divorced, how often does the other parent see child? __________________________________

Custody visitation schedule: ____

Please list the adults with whom the child is living now and complete the following information:

Name: __________________________________ Occupation: _______________________________
(last) (first)
Relationship: _____________________________ Education: _______________________________

Name: __________________________________ Occupation: _______________________________
(last) (first)
Relationship: _____________________________ Education: _______________________________

Name: __________________________________ Occupation: _______________________________
(last) (first)
Relationship: _____________________________ Education: _______________________________

Primary caregiver: _______________________________________

Is child in state's custody? Y/N ____ date _______________

Siblings name:	Age	Relationship/school	Social, academic or medical problems	Living where?
____________________	____	_________________	________________________________	_____________
____________________	____	_________________	________________________________	_____________
____________________	____	_________________	________________________________	_____________

How does child get along with siblings? Explain: ____

Please list any adults who do not live with the child but are very involved in the child's life:

1. Name: ____ Relationship: ________________________
(last) (first)
Contact: ____

2. Name: ____ Relationship: ________________________
(last) (first)
Contact: ____

What questions or concerns would you like to have answered by this evaluation?

____

____

____

____

____

PREGNANCY:

Duration _____________ weeks Was mother under a doctor's care? Y/N _____

Pre-natal

Complications during pregnancy for mother or child? Explain: ____

Smoking before/during pregnancy (amount): ____

Alcohol consumption before/during pregnancy (amount): ____

Caffeine consumption before/during pregnancy (amount): ____

Medications or other drug usage before/during pregnancy (type & amount): ____________________________

____

Peri-natal

Birth weight: ___________________________ Length: ______________________________

Any complications at birth? ____

APGAR scores: ______ ______ ______

Post-natal

Any complications after birth for child or mother? ____

____

____

INFANCY/TODDLER PERIOD

Did you breast or bottle feed your child? (How long?) ____

Were there any particular concerns/difficulties associated with feeding? ___________________________________

Were there any particular concerns/difficulties associated with sleeping? __________________________________

DEVELOPMENTAL MILESTONES

If you can recall, please note if any of the following developmental milestones for your child presented any particular concerns. This would include if any of these milestones were reached earlier or later than your child's physician considered normal or expected.

Age

______ slept through the night
______ smiled
______ sat without support
______ crawled
______ first step
______ first word ___________________ 1 word other than Mama or Dada
______ walked without assistance
______ 2 word phrase
______ bladder training began , ______ success
Did bedwetting occur after toilet training? Y/N ____ When/age? ________
______ bowel training began , ______ success
Did soiling occur after toilet training? Y/N ____ When/age? ________
Any medical reason for bedwetting or soiling? ____
______ began dressing self, buttoning clothing/tying shoelaces
______ count to "3"
______ count to "10"
______ began to show interest in books

______ realized written words have meanings

Any problems during the first 4 years?

Eating Y/N _____
Sleeping Y/N _____
Motor skills Y/N _____
Failure to thrive Y/N _____
Temper tantrums Y/N _____
Separating from parents Y/N _____
Excessive crying Y/N _____

COMPREHENSION AND UNDERSTANDING

Do you consider your child to understand directions/situations as well as other children his or her age? Y/N _____

____

If no, why not? ____

MEDICAL HISTORY

Childhood diseases, such as measles/mumps/chicken pox/whooping cough (describe any complications):

____

Neurological exam? ________________________________

Operations? ______________________________________

Hospitalizations for illness other than operations? ___________________________________

____

Has your child ever experienced any of the following? If yes, please give dates and details:
___ Head injuries/loss of consciousness ______________________________________
___ Convulsions or seizures ____
___ Coma, fever over 104/or sustained high fever ________________________________
___ Meningitis or encephalitis ____
___ Immunization reactions ____
___ Muscle or bones issues, like broken bones, etc. ______________________________
___ Eye problems ____
___ Ear problems ____
___ Poisoning ____
___ Allergies ____
___ Lead poisoning ____
___ Tic or repetitive movements with face, hands, mouth, etc. _______________________
___ Rashes, skin disorders, eczema, bruises easily ______________________________
___ Urinary track problems/constipation or diarrhea ______________________________
___ Asthma or other respiratory or breathing problems ____________________________
___ Heart conditions or concerns ____

___ Gastro-intestinal conditions, heartburn, ulcers ______________________________

Has child ever had difficulties with:
Walking Y/N _____
Unclear speech Y/N _____
Eating/feeding problems Y/N _____
Underweight problems Y/N _____
Overweight problems Y/N _____
Colic Y/N _____
Sleep problems Y/N _____
Difficulty learning to ride a bike, skip, throw or catch, walking, buttoning, tying shoes, writing Y/N _____

PRESENT MEDICAL STATUS

Present illness(es) for which child is being treated: ______________________________

____

What medication is child currently taking and why? ______________________________

____

Prescribing doctor's name: ______________________________

Dates of last medical examination: ______________________________

Name of child's current physician: ______________________________

List names of other professionals consulted, (i.e. doctor specialists, social workers, counselors, advocates) and list dates of contacts: ______________________________

____

SCHOOL HISTORY

Identify schools, when attended and rate the experience:

	Name:	Year(s)	How was this experience? Any problems or concerns?
Nursery/preschool:	______________		______________
Kindergarten:	______________		______________
Elementary school(s):	______________		______________
	______________		______________
Jr./Sr. High school(s):	______________		______________
	______________		______________

Please briefly summarize any concerns or problems your child has been experiencing related to school or outside of school (i.e. learning, socializing, behavior, attention problems) ____

____

Has your child ever been retained in school or skipped a grade? ____

OTHER FAMILY MEDICAL HISTORY

Have any family members had any of the following? If yes, please specify family member's relationship to this child. If child is not living with biological parents, please include health information on biological parents, if known.

__ Cancer__________________________
__ Diabetes ________________________
__ Physical handicap ________________
__ Tuberculosis ____________________
__ Hemophilia _____________________
__ Muscular Dystrophy ______________
__ Sickel-Cell Anemia _______________
__ Tourette's Syndrome ______________
__ Cerebal Palsy ___________________
__ Kidney Disease __________________
__ Multiple Sclerosis ________________
__ Behavior disorder ________________
__ Mental illness ___________________
__ Nervousness ____________________
__ Reading problems ________________
__ Speech/Language disability ________
__ Severe head injury ________________
__ Cystic Fibrosis __________________________
__ Heart Disease ___________________________
__ Stroke _________________________________
__ Alzheimer's Disease ______________________
__ Huntington's Chorea _____________________
__ Parkinson's Disease ______________________
__ Tay-Sachs Disease _______________________
__ Birth Defects ___________________________
__ High blood pressure ______________________
__ Migraine headaches ______________________
__ Alcohol/Drug Abuse ______________________
__ Emotional disturbance ____________________
__ Mental retardation _______________________
__ Seizures or Epilepsy ______________________
__ Other learning disabilities _________________
__ Food allergies ___________________________
__ Other: describe __________________________

SOCIAL, EMOTIONAL, AND BEHAVIORAL DEVELOPMENT

Has your child been diagnosed with any of the following psychological/psychiatric or mental health conditions?

___Autism Spectrum Disorder
___AD/HD
___Anxiety
___Obsessive/Compulsive Disorder
___Depression
___Adjustment Disorder
___Tic Disorder
___Eating Disorder (Anorexia/Bulimia)
___Post Traumatic Stress Disorder
___Bipolar Disorder
___Oppositional-Defiant Disorder
___Conduct Disorder
___Pervasive Developmental Disorder
___Intermittent Explosive Disorder
___Tourette's Disorder
___Substance Abuse
___Other (Please Specify) _________________________________

If yes, who diagnosed the condition? ____

Was an evaluation report completed? ____

When was the diagnosis made? ____

Has your child ever been the victim of physical or sexual abuse? _____________________

Has your child even been the perpetrator of physical or sexual abuse? __________________

PEER RELATIONSHIPS

Does your child seek friendships with age appropriate peers? Y/N______
Is your child sought by age appropriate peers for friendship? Y/N______
Does your child play primarily with children his or her own age? Y/N______
How many friends does your child have? ___________
Describe briefly any problems your child may have with peers: ____
Do your child's friends engage in any of the following behaviors? Drink beer/wine/liquor, chew tobacco, smoke cigarettes, use illegal drugs, use inhalants/inhale toxic substances: ______________________________________

____

Does your child use substances? ____

Does your child exhibit any of the following behaviors:

Is easily over stimulated in play Y/N ____
Has a short attention span Y/N ____
A lack self control Y/N ____
Seems unhappy most of the time Y/N ____
Withholds affection Y/N ____
Hides feelings Y/N ____
Seems overly energetic in play Y/N ____
Seems impulsive Y/N ____
Overreacts when faced with a problem Y/N ____
Seems uncomfortable meeting new people Y/N ____
Requires a lot of parental attention Y/N ____
Cannot calm down Y/N ____
Has fears Y/N ____ If yes, please describe: ____

HOME BEHAVIOR

All children exhibit, to some degree, the kinds of behavior listed below. Check those that you believe your child exhibits to an excessive or exaggerated degree when compared to other children his or her age.

		Age of onset:
_____	Is your child easily over stimulated?	____________
_____	Is your child over active or more active than siblings or kids his/her own age?	____________
_____	Is your child impulsive or lacks self-control?	____________
_____	Is your child easily frustrated?	____________
_____	Does your child have temper outbursts?	____________
_____	Does your child interrupt frequently?	____________
_____	Does your child not listen when being spoken to?	____________
_____	Does your child hit or hurt other people?	____________
_____	Does your child lack awareness around safety?	____________
_____	Does your child have an excessive number of accidents?	____________
_____	Does your child not learn from their experiences or from being corrected?	____________
_____	Does your child have a poor memory?	____________
_____	Does your child have a short attention span?	____________
_____	Any concerns about your child's mood?	____________
_____	Is your child overly shy or anxious?	____________

INTERESTS AND ACCOMPLISHMENTS

What are your child's favorite activities? (sports, hobbies or other interests) ______________________________

Has your child's participation in any of the above activities declined recently? Y/N _____

Does your child use the computer to surf the internet? Y/N _____

Do they participate in: Chat rooms Y/N ____ My space Y/N _____ Video game usage Y/N ____

Does your child have any chores or responsibilities at home? Y/N _____ If so, what are they? _______________

____

What does your child dislike doing most? ____

What makes them angry? ____

ADDITIONAL REMARKS

Please describe any of the following that have occurred (please list dates). Also, please explain how you feel they have impacted your child.
Changes of family residence/financial status ____

Illness (health or mental) or deaths involving family members or persons well known to the child and family

____

Loss of child's friend due to moving ____

Separation, divorce, remarriage (list contact with non-custodial parent) ____________________

Drug or alcohol usage (adult and/or child) ____

Physical or sexual abuse ____

Witnessing of violence or abuse ____

Any other issues which might be impacting your child's functioning: _____________________

____

What are your child's areas of greatest accomplishments or challenges? What qualities of your child make you the most proud? ____

____