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CHILDREN'S DIAGNOSTIC QUESTIONNAIRE

Today's Date ____________________ Child's Social Security # _________________________

IDENTIFYING INFORMATION

Child's Name _________________________________ (M)____ (F)___Date of Birth________

Street Address ____

City ______________________ State ________ Zip Code ________

Telephone/TTY _______________ Email address ___________________

Referred by ____

Parent 1 Full Name _______________________________________Age _________________

Address ____

Parent 2 Full Name _______________________________________Age _________

Address ____

Parent 1 Job Title ____Telephone #_____________

Parent 2 Job Title ____Telephone # ____________

Reason for today's evaluation:

____

____

Other children at home:

Name ____Age _________

____Age __________

____Age __________

Which languages are spoken at home?

____

Child's Doctor _________________________________ Address

____

City _________________________ State ____________ Zip Code _______________________

Telephone # ___________________________________

Mother's previous pregnancies (include miscarriages) ___________________________________

Illnesses or complications during pregnancy with this child? ______________________________

List drugs/medications taken during this pregnancy: ____________________________________

Where was this child born? ____

Conditions during this child's birth:

Length of pregnancy _______________ How long was labor? __________________

Was birth by Cesarean Section ______ Breech birth?__________________________

Birth weight _____________________ Was baby in intensive care? ____________

Did baby need transfusion? ________ Did baby have jaundice? _______________

Did baby have anoxia or respiratory distress? ____________________________________

Immediately following birth:

Did the baby have difficulty sucking and swallowing in the first few days of life? ______

Were there any feeding difficulties in early infancy? ______________________________

Did the baby have a newborn hearing screening exam? Yes/No (please circle)

- What were the hearing screening results? Pass/Refer (please circle)

Were there any other conditions of concern? ___________________________________

___

Health History

Please note if your child has or has had any of the following:

Allergies	Asthma	Chicken Pox	CMV
Ear Infections	Encephalitis	Frequent colds	Head injuries
Heart problems	High fever	Kidney problems	Measles
Meningitis	Mumps	Scarlet fever	Seizure disorder
Vision problems	Other:		

Are immunizations up to date? ____

(please attach immunization record)

Were there any reactions to immunizations? ____

Has child been hospitalized? _______________ Reason for hospitalization ________________

Name of hospital ________________________ Length of stay _________________________

Has child had surgery? What type and when ____

Has medication ever been used for behavior or emotional issues? ________________________

Does the child take any medications regularly?

____

DEVELOPMENTAL HISTORY

At what age did child:

Show visual response to mother _________ Crawl ________ Sit ________ Walk ________

Become Toilet Trained _________ Ride a tricycle ________ Bicycle _________

Does child have an unusual gait, fall or lose balance easily? _____________________________

Can child jump _______ hop _____ skip _______Does child prefer right or left hand ________

FAMILY HISTORY

Has any member of your family been treated for: (indicate who)

Deafness or Hearing Loss _______________________ Developmental delay_______________

Language Disorder ____________________________ Learning Disability_________________

Reading diffiulty ______________________________ Speech problems __________________

Vision problems ______________________________ Other ___________________________

HEARING, SPEECH, LANGUAGE BEHAVIOR

Does child respond to sounds when the source of the sound is out of sight? _________________

If so, what specific sounds ____

Does child want TV/Radio excessively loud? ____

Does child distinguish between different sounds? (e.g., telephone vs. doorbell, etc.) __________

Does child respond to his or her name? ____

At what age did:

baby babble? _____________ imitate sounds? ______________ Say first word? _____________

phrases? ______________________________ sentences ______________________________

Does your child understand any words or phrases?
Please list: ____

How do you get your child's attention?

Please describe: ____

How do you communicate with your child? Voice alone _______ Sign _____ Both __________

Give example of communication with child ___________________________________

____

How does your child get what he/she wants? Gesture ______________ Voice ______________

Voice and Gesture _____________________ Describe situation: (i.e., "wanting bottle")

____

____

What speech sounds have you heard your child make? Please list: (i.e., ba,ee,etc.)

____

Does your child have tendency to "tune in and out" of listening situations? _________________

____

Has child ever been seen by an ear doctor? __________ If yes, please provide information:

Doctor's Name __________________ Doctor's Address _______________________________

What did Doctor recommend? ____

Does child wear a hearing aid? __________________When was it purchased?_______________

Who recommended the hearing aid? ____

Name and Model ________________________ Ear: Right _______ Left _______ Both _______

When does the child wear the hearing aid? ____

Does child use an FM system?

____

Has child been seen by any other doctors (e.g. eye doctor, neurologist, kidney specialist)?
If yes, please provide information: ____

____

SOCIAL AND EMOTIONAL BEHAVIOR

Does child have any specific food preferences? _______________________________________

At what age did child play with other children? _______________________________________

Does child prefer playing alone or with other children? _________________________________

What ages are child's playmates? ____

Is your child more interested in people? __________________ or objects?
____

Is your child easily distracted?
____

Is your child easily managed at home? ____
at school? ____

SCHOOL INFORMATION

What school does your child attend? ______________________________ Grade ____________
Address ____
Phone number: ________________________Classroom Teacher ________________________
List schools previously attended:

____
Name of School   Address   Dates of Attendance

____
Name of School   Address   Dates of Attendance

Has your child repeated a grade? _______________________Which one? __________________

If child has received special services at school (resource room, remedial reading, speech therapy, supplement help, special class or school, psychological evaluation, etc.) please answer the following section.

Type of Service	Date Received	Name of Specialist

HOME INFORMATION

Has this child's development been in any way different from that of the other children in your family? (If your answer is yes, please describe) _______________________________________
____
____

Is there agreement in your household on the nature of your child's problem?

____

____

____

FINANCIAL INFORMATION

Family Income ____

Do you or your child receive:

SSI ______________________________#_________________________________

Welfare ___________________________#_________________________________

Medicaid __________________________#________________________________

Medicare __________________________#________________________________

Do you have Health Insurance and/or Major Medical? _________________________________

If yes - Name of Carrier ___________________________________Policy # _____________

Form Completed by ____

Relationship to child ____

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