

Child Development and Behavior Questionnaire

DATA REQUIRED BY THE PRIVACY ACT OF 1974 (5 U.S.C. 552a)

AUTHORITY: PL 94-142 (Education for All Handicapped Children Act of 1975); PL 95-561 (Defense Dependent's Education Act of 1978); DODI 1342-12 (Education of Handicapped Children in DODDS), 17 December 1981; 10 USC 3013; 20 USC 921-932 and 1401 et seq.

PRINCIPAL PURPOSES: To obtain medical, behavioral and developmental history needed to asses, evaluate and document child's education and/or health needs.

ROUTINE USES: Information will be used to screen, evaluate and document health related and special education needs of children referred to the Developmental Pediatrics Service. Information will assist in providing, planning and coordinating appropriate health and educational services.

DISCLOSURE: Voluntary. If the requested information is not furnished, comprehensive health care may not be possible, but care will not be denied.

RELEASE OF INFORMATION

I understand that submitting this form electronically, all or in part, by the parent, guardian, or agent of the child, constitutes agreement to release the form's information and contents to the Army Medical Department for the purpose of evaluating my child's need for special medical, psychological, or educational services.

***Note: If the following information is not correct, or you do not agree, do not submit this form. Contact the Project Assist Office for instruction.**

Child's name: _____

Date of birth: _____

Sponsors info: _____

Branch of service: _____

Telephone: hm _____ wrk _____

Email: _____

Date Submitted: _____ Submitted by: _____

Developmental and Behavioral Questionnaire Instructions

Please enter all information as accurately as possible. There are several parts to the questionnaire and each part is saved individually. You must, however, save each part by selecting the **SUBMIT** button on each form to continue to the next part. If you are unable to finish the form in one session you may return later to complete it. Do not click on the **SUBMIT** button until all the information for the current part has been completed as accurately as possible.

Part 1. Problem History

A.

Please list the child's major problem with which you believe assistance is needed.

Problem Age noted

List medical/education diagnosis (if known)

B. Please describe any family problems such as death, serious illness, accidents, martial conflicts, or upsetting separation of child from parents that your feel may have affected your child.

C. Has your child been evaluated or treated? (Please include all physicians, school evaluations, State clinics, therapists.) Date Where What was done/told/or diagnosed

Part II. Pregnancy History

A. Pregnancies:

1. Did you at any time have problems getting pregnant yes no
2. Did you use any form of contraception? yes no
3. Was this a planned pregnancy? yes no
4. Explanation if desired of above:
5. List all pregnancies (including the child being evaluated, deceased children or miscarriages in order of occurrence.)

No. Child's full name, Age, Health or development problem

B. Prenatal History:

The following questions refer to the pregnancy with the child who is being evaluated

1. Did you have any problems getting pregnant with this child?
2. During which month did you start prenatal care?
3. Where?

4. Weight before pregnancy:

Weight at delivery:

5. Medications:

a. Did you take vitamins and iron tablets during pregnancy ? yes no

b. Did you take any other medicine during pregnancy? yes no

c. if answer to b is yes, please indicate below the name of the medicine , when you took it and for how long. Example: Aspirin, aspirin equivalent, pain medicine, cold tablets, cough medicine, steroids, hormones, antibiotics, antihistamines, anticonvulsants, tranquilizers, sedatives, stimulants, hallucinogens, narcotics, stomach medicine, asthma medicine, water pills, medicine for diabetes. (Other medicine).

d. Did you smoke cigarettes during pregnancy? yes no

If yes, how many cigarettes per day ? _____

e. Did you drink alcohol during pregnancy? yes no

If yes, how many drinks per day or week? _____

f. Did you smoke marijuana during the pregnancy? yes no

6. When did you first feel the baby move?

7. Did you have or did any of the following occur during this pregnancy? Please Check.

Fever Viral Infection morning sickness vaginal bleeding swelling high blood pressure toxemia urinary or kidney infections sugar or protein in urine threatened miscarriage special diet diabetes heart problem asthma convulsions or seizures German Measles (rubella) amniocentesis Rh factor problem X-rays surgical procedures accidents worries concerns or problems

Other:

8. How long was your labor?

9. How was your child delivered?

10. Were there any problems with delivery? If yes, explain:

Part III Infant's condition at birth and in nursery:

Birth Weight:

Length:

Head Circumference

Apgar Scores:

| Question | (Yes or No) or explain |
|--------------------------|------------------------|
| Breath immediately | |
| Cried immediately | |
| Resuscitation required | |
| Required oxygen at birth | |
| Was blue | |
| Was jaundiced (yellow) | |
| Had seizures/convulsions | |
| Had infection | |
| Had a skin rash | |

| | |
|--|--|
| Had a bleeding problem Had low blood sugars Procedures or treatments that your child may have had: Fluids by needle yes no Transfusions Feeding by a tube Incubator Oxygen therapy Breathing machine Special lights for jaundice (yellowness) Chest tube Treatment with antibiotics for infection | |
|--|--|

Part IV. Early Childhood Behavior Profile: (1st 2 years of life)

Please evaluate your child in reference to these behaviors on a scale of 1-5; 1 being no problem, 3 being average, and 5 being a severe problem. Check the appropriate number.

| | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| 1. Feeding difficulties 2. Sleeping difficulties 3. Rhythmic behavior (head-banging, body-rocking) 4. Hard to comfort or console 5. Floppiness 6. Cried often and easily 7. Not affectionate 8. Poor eye contact | | | | | |

Part V. Present Child Behavior Profile

Part VI. Parents Education and Occupational history

1. Father
 - a. School level completed
 - b. Present occupation
2. Mother
 - a. School level completed
 - b. Present occupation

VII. Child's School History

A. List Previous schools and dates that child attended:

B. Has Child ever repeated a grade Yes No

If yes, explain

C. Is or had the child been in special education? Yes No

VIII. Family Medical History

A. Please indicate on the chart below family members who have had any of the identified conditions. If relative with condition is deceased, please indicate so.

| CONDITION | YES NO | IN WHOM | DECEASED(chk) |
|--|---------------|----------------|----------------------|
| 1. Mental health problems | | | |
| 2. Mental retardation | | | |
| 3. Birth defects | | | |
| 4. Seizures/Convulsions | | | |
| 5. Tuberculosis | | | |
| 6. Muscle diseases | | | |
| 7. Neurological disease 8. Diabetes | | | |
| 9. Cancer | | | |
| 10. Glandular disorders | | | |
| 11. Thyroid disorders | | | |
| 12. Kidney disorders | | | |
| 13. Visual problems | | | |
| 14. Hearing problems | | | |
| 15. Genetic conditions | | | |

B. Explain any of the above conditions:

C. Are the parents of this child blood-related yes/no

IX. Child's School History (If in school)

A. List previous schools and dates that the child attended:

B. Has the child ever repeated a grade yes/no
If yes, please explain

C. Is or has the child been in special education Yes/No

D. If your child has problems with school, describe how the teachers have characterized your child's problem

E. Identify the areas that you consider a problem:

1. Clumsy or uncoordinated Yes/no
2. Math problems
3. Reading problems
4. Spelling problems
5. Writing problems
6. Memory problems
7. Speech problems
8. Emotional problems
9. Behavioral problems
10. Specific classroom or teacher problems

IX. Summary

A. Please describe your child's problems and your concerns. Indicate when your first noted the problem and if you feel there may have been circumstances which contributed to the problem.

B. What do you think we might be able to offer you and your child?

C. Is there anything that hasn't been covered in this questionnaire that you feel is pertinent to your child's problem. If so please explain or summarize the problem if you wish.