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Phone: 778-395-8752 Fax: 778-395-8759

DEVELOPMENTAL QUESTIONNAIRE

Date: ______________________________

Completed by: _____________________ **Relationship to the child:** ____________________

Who referred you to Symbiosis: ____

Child's Particulars:

Name:

Date of birth/Age:

Address:

Parent's/Guardian's particulars: *(please strike off where applicable)*

Father's/Guardian's Name: ____

Mother's/ Guardian's Name: ____

Contact number: ____

E-mail: ____

Occupation:

Mother: __________________________ Father: ____

Has your child been diagnosed with (Please mark (✔) to all that applies):

- □ Autism Spectrum Disorder
- □ Anxiety Disorder or Mood Disorder
- □ Down Syndrome
- □ Sensory Processing Disorder or Sensory Integration Dysfunction
- □ ADD /ADHD
- □ Cognitive Delay
- □ Learning Disabilities
- □ Other (specify):

Reason for referral (Please mark (✔) to all that applies):

- □ Gross motor skills
- □ Handwriting skills
- □ Feeding Challenges
- □ Developmental Delays
- □ Fine motor skills
- □ Sensory skills
- □ Other (specify):

- Please describe, in your own words, what are your current concerns for your child at this time (i.e. related to academics, activities of daily living, relationships, sensory, motor, play, feeding etc.)

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- What goals do you want to achieve from your child's intervention program at Symbiosis? Please be as specific/detailed as possible.

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MEDICAL HISTORY

It is very important to have as complete a medical history for your child as possible. Please fill out the grid below. **(Please mark (✔) to all that applies)**

Pre-Natal (During pregnancy)	**Peri Natal** (During the delivery)	**Post Natal** (Within 2 years age)
□ Nothing significant	□ Nothing significant	□ Nothing Significant
□ Accident/Trauma	□ Premature difficult/Prolonged labor	□ Jaundice
□ Malnutrition	□ Caesarian/Forceps _____ Weeks	□ Head Injury
□ Acute emotional	□ Cord around the neck	□ Convulsions
□ Unwanted pregnancy	□ Delayed birth cry	□ Malnutrition
□ Excessive medication	□ Low Birth Weight	□ Seizures
□ Drugs/Alcoholism	□ Resuscitation	□ High fever

EARLY CHILDHOOD OR CURRENT CONDITION (Please mark (✔) to all that applies)

□ Frequent colds/respiratory illness	□ Seizures or convulsions
□ Stomach disorder/stomach pain/ Constipation/diarrhea problems	□ Birth defect/genetic disorder
□ Frequent strep throat/sore throat (Tonsils or adenoid problems?)	□ Failure to gain weight/feeding problems
□ Frequent ear infections? (PE Tubes placed?)	□ Hearing loss/ear disorder
□ Lung condition/respiratory disorder/ Allergies or asthma	□ Eye infections/ Visual disorder/vision problems
□ Head injuries or concussions	□ Neurological disorder

HOSPITALIZATIONS AND/OR SURGERIES

Please list the dates of any hospitalizations your child has had and the reason. List the dates of any surgeries your child has had and the reason.

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MEDICATIONS

- List any medications your child has consistently used **in the past:**

Medication:_________________________ Purpose: _______________________________

- List any medications your child is **currently** taking:

Medication:_________________________ Purpose:_______________________________

DEVELOPMENTAL MILESTONES

We would like to have information about your child's developmental milestones. Indicate the age when your child first did each of the following **INDEPENDENTLY**. Or, if you cannot recall/find a specific age, please mark whether you believe your child accomplished the milestone early, on time, or late. If your child has not yet achieved the milestone, write N/A in the age column.

MILESTONES	APPROXIMATE AGE WHEN ACHIEVED
Held head up	
Rolled over	
Sat unsupported	
Crawled	
Stood alone	
Walked by self	
Said first words	
Ran by self	
Followed simple 1 step directions	
Rode bicycle without training wheels	
Demonstrated handedness	
Knew colors	
Counted to 5	
Knew alphabet	
Bladder trained- days	
Bladder trained- nights	
Fully toilet trained	

VISUAL DEVELOPMENT

- Has your child experienced any problems with his/her eyesight or vision?

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- Are there any current problems of which you are aware?

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AUDITORY DEVELOPMENT

- Has your child experienced any problems with his/her hearing? (i.e. operations, infections, tubes placed)

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- How often does your child have ear infections? (Please mark (✔) to all that applies)

☐ Seldom ☐ Sometimes ☐ Often

PREVIOUS TESTING AND TREATMENTS

Has your child had any previous ASSESSMENTS or TREATMENTS?

	Yes/N	DATE	PLACE	Report available – Y/N
Any Medical				
Occupational Therapy				
Psychological				
Speech-Language				
Audiological				
Physical Therapy				
Feeding				
Behaviour Consultancy				

SPEECH AND LANGUAGE DEVELOPMENT

How would you describe your child's speech and language development?

□ Normal □ Delayed □ Advanced

SENSORY and MOTOR DEVELOPMENT (Please mark (✔) to all that applies)

☐ My child seems to be **overly sensitive** to sensory experiences more so than most people:
□ Auditory □ Tactile □ Visual □ Movement □ Taste □ Smell

☐ My child **doesn't seem to react** to sensory experience as readily as most people:
□ Auditory □ Tactile □ Visual □ Movement □ Taste □ Smell

☐ My child **actively seeks out** sensory experiences more so than most people:
□ Auditory □ Tactile □ Visual □ Movement □ Taste □ Smell

☐ My child has **difficulty differentiating** sensory experiences. (e.g. confuses sounds, can't find objects in drawer or bag without looking, bumps into things)

☐ My child has **trouble learning new movements.**

☐ My child tends to be **clumsy** and has **balance and coordination problems.**

EDUCATION

In general, how would you describe your child's experience/learning at school from kindergarten to the present time?

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Please give us more detailed information about any difficulties your child encountered in school beginning with the earliest experience, **whichever applicable**:

Initial school adjustment

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Preschool/Daycare

____

____

Primary (K-3rd Grade)

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____

Junior (4th - 6th Grade) and higher

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____

Name of Current School:___________________________________**Grade:** ___________

Describe any concerns shared by the teacher:

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____

____

Has there been remedial help given **inside** the school system? ☐ Yes ☐ No

If yes, please describe:

____

____

DAILY LIVING SKILLS

Basic ADLs	Independent	Needs Assistance	Dependent	Additional Comments
Feeding				
Utensils Manipulation				

Eating/drinking				
Personal Grooming and Hygiene				
Can wash face and upper body				
Can wash trunk and lower body				
Dressing				
Shirt/Upper Limb Garments				
Pants/Lower limb Garments				
Socks/Shoes				
Mobility and Transfers				
Indoor mobility				
Outdoor Mobility				

Play skills:

	Performs without help	**Performs with help**	**Yet to attempt**	**Comments**
Play alone				
Group play				
Play by the rules				
Able to take turns				

Comments:____

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PERSONALITY PROFILE

- What are your child's strengths?

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- What do you enjoy most about your child and family?

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- What kind of interest and activities does your child have (hobbies, sports, clubs)? Please list them in order of preference beginning with the favorite activity.

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ADOPTION HISTORY (please skip if not relevant)

- Please describe the circumstances surrounding the adoption.

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- At what age was the child adopted?

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- Was the child previously in a foster home?

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- What was the child's response to the new home?

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- Has there been positive bonding and engagement between the child and adoptive parents?

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- Is your child aware of his/her adoption?

  ____

SOCIAL SKILLS:

- How does your child get along with other children? (School as well as at home)

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- How do other children relate to your child? (School as well as at home)

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- How does your child get along with his teachers or other adults?

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Thank you for filling the questionnaire.

PLEASE RETURN BY POST, FAX OR EMAIL BEFORE THE DATE OF CONSULTATION/ ASSESSMENT.

The Symbiosis Pediatric Team