Child development questionnaire

Department of Pediatrics, Ichinomiya Medical & Habilitation Center

Child’s Name: ( ) Age: ( ) years ( ) months Sex: ( Male / Female )

Medical record ID ( )

1. As a result of detailed examination by our team, if we are able to make a diagnosis for your child, can we tell the results of the diagnosis honestly?
 ( Yes, No )
2. This question is for those who answered "Yes". In that case, would it be okay if your child is with you in the discussion?
 ( Yes, No )
3. What concerns would you like to discuss today? 　Please answer briefly.
4. Has your child ever been diagnosed at other medical institution?
 ( Yes, No )
5. This question is for those who answered "yes". If you don't mind, please answer the following.
Medical facility ( 　　　　　　　　　　　　　　　)
Diagnosis (　　　　　　　　　　　　　　　 )
6. I would like to ask you about your child. Please answer briefly.
Physical illness (　　　　　　　　　　　　　　　　　　　　 )
Personality ( 　　　　　　　　　　　　　　　　　　　　)
What does your child like? ( 　　　　　　　　　　　　　　　　　　　　)
What does your child dislike? (　　　　　　　　　　　　　　　　　　　　 )
7. About pregnancy and childbirth
Abnormalities in pregnancy 　(No/Yes) If yes ( )
Abnormalities in childbirth (No/Yes) If yes ( )
Asphyxia (No/Yes)
Jaundice (Yes/No) Jaundice treatment ( phototherapy / exchange transfusion )
Gestational age ( weeks and days )
Measurement at birth:
weight g , height cm ,
head circumference cm , chest circumference cm
Age of parents at childbirth ( Father yo, Mother yo )
8. I would like to ask you about development of your child
When did your child do for the first time? ( Answer 1 year old as 12 months)
 social smile months , hold his/her head up months , roll over months ,
 sit without support months , walk alone months , speak a word months ,
 speak in two-word sentences months , shy with strangers months
Self care activity
 Meal ( possible alone / partial assistance/full assistance )
 Changing clothes ( possible alone/partial assistance/full assistance )
 Urination ( possible alone/partial assistance/full assistance )
 Defecation ( possible alone/partial assistance/full assistance )
Hypersensitivity: regarding the following five senses
 Hypersensitivity to sound (e.g., dislikes the sound of a vacuum cleaner):
 Hypersensitivity to vision (e.g., likes rotating objects):
 Hypersensitivity to touch (e.g., likes certain towels):
 Hypersensitivity to taste (e.g., dislikes certain foods) :
 Sensitivity to odors (e.g. dislikes the smell of fried foods):
Dislikes exercise: If yes, please write in detail.
 Not good at full-body exercise ( yes/no ) If yes:
 Has clumsy with his/her hands ( yes/no ) If yes:
9. Development in infancy ( Please tell us about the situation up to the age of 1 )
 Please circle yes or no that applies to your child
1. Had social smiles ( yes / no )
2. Had shyness with strangers ( yes / no )
3. Had crying at night or night terrors ( yes /no )
4. Had sleep problems ( yes / no )
5. Had dietary problems ( yes / no )
6. Was quiet and didn't need much help ( yes / no )
7. Was difficult to make eye contact ( yes / no )
8. Was difficult to respond when you call his/her name ( yes / no )
9. Has difficulty playing with others ( yes / no )
10. Didn’t like being cuddled ( yes / no )
11. Did not try to copy what you do ( yes / no )
12. Was not interested in toys ( yes / no )
10. Regarding early childhood development ( Please answer if ages 3 and older )
Please circle yes or no that applies to your child in early childhood.
1. Was difficult to make eye contact ( yes / no )
2. Was difficult to respond when you call his/her name ( yes / no )
3. Was hyperactive ( yes / no )
4. Often got lost ( yes / no )
5. Didn’t care even without parents ( yes / no )
6. Liked playing alone and did not play with other children ( yes / no )
7. Delayed speech onset ( yes / no )
8. Had stopped saying the words once spoken ( yes / no )
9. Often parroted (ecolalia) ( yes / no )
10. Had persistent pattern ( yes / no )
11.Had strange behavior ( yes / no )
 Details: (　　　　　　　 　)
11. Regarding kindergartens and nursery schools .
 Admission : 20 / / , Kindergarten / Nursery school, its name ( )
　1. She/He used to participate in group activities such as sports days ( yes / no )
　2. She/He often played with other children ( yes / no )
 3. Teachers or daycare workers pointed out some problems ( yes / no )
 　　Details: (　　　　　　　 　　　 　)
12. Please answer the following, if you have a school age child.
 Does your child have problems with From when Specifics / Support
 conversation (yes/no)
 handwriting (yes/no)
 reading (yes/no)
 calculation (yes/no)
 others (yes/no)

Recent Report Cards ( Elementary School / Junior High School ; 　　grade　 semester)
 Japanese ( ) Music ( )
 Arithmetic /Mathematics ( ) Arts and Crafts ( )
 Social studies ( ) Physical education ( )
 Science ( ) Technology /Home economics ( )
 English ( )
13. School life problems
　　　　　　　　　　　　　　　　Period 　　　 Details
 School absenteeism (yes/no) 　 　~
 Domestic violence (yes/no)　　　 　 　~
 Got bullied (yes/no)　　　 　 　~
 Has trouble with teachers (yes/no) 　 　~
14. About your family ( Please circle the persons living with your child )
 Father, Mother, Paternal grandfather, Paternal grandmother,
 Maternal grandfather, Maternal grandmother
 Brothers and sisters: ( ) Others: ( )
 Have you ever had any problems at home ? (yes/no)
　(Parental discord, family illness, divorce, financial problems, others( ) )
 If yes, please explain in detail.

 Are there any complicated situations at home right now? (yes/no)
 If yes, please explain in detail.