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 (

Jaundice (Yes/No) Jaundice treatment (phototherapy / exchange transfusion)

Asphyxia (No/Yes)

	Gestational age (weeks anddays)				
	Measurement at birth:				
	weightg, heightcm,				
	head circumferencecm , chest circumferencecm				
	Age of parents at childbirth (Fatheryo, 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 smilemonths , hold his/her head upmonths , roll overmonths ,				
	sit without supportmonths , walk alonemonths , speak a wordmonths ,				
	speak in two-word sentencesmonths , shy with strangersmonths				
	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:				
0					
9.	· · · · · · · · · · · · · · · · · · ·	ituation up to the age of 1)			
	Please circle yes <u>or</u> no that applies to your child 1. Had social smiles	(vos / no)			
		(yes/no)			
	2. Had shyness with strangers 2. Had shyness with strangers	(yes/no)			
	3. Had crying at night or night terrors4. Had sleep problems	(yes/no)			
	1 1	(yes/no)			
	5. Had dietary problems 6. Was quiet and didn't need much halp	(yes/no)			
	6. Was quiet and didn't need much help 7. Was difficult to make eve contact	(yes/no)			
	7. Was difficult to make eye contact 8. Was difficult to respond when you call his/her name.	(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)
1 0. Regarding early childhood development (Please answer in	f ages 3 and older)
Please circle yes or no that applies to your child in early childh	nood.
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: ()
 She/He used to participate in group activities such as sport She/He often played with other children Teachers or daycare workers pointed out some problems Details: ((yes / no) (yes / no) (yes / no))
1 2 . Please answer the following, if you have a school age child Does your child have problems with From when conversation (yes/no) handwriting (yes/no)	d. Specifics / Support
reading (yes/no) calculation (yes/no)	
reading (yes/no) calculation (yes/no) others (yes/no) Recent Report Cards (Elementary School / Junior High School Japanese () Music (Arithmetic /Mathematics () Arts and Craft Social studies () Physical education) ss ()

	School life problems	Period	Details	
	School absenteeism (yes/no)	~		
	Domestic violence (yes/no)	~		
	Got bullied (yes/no)	~		
	Has trouble with teachers (yes/no)	~		
Н	lave you ever had any problems at he	ome?	(yes/no)	,
	Father, Mother, Paternal grandf	ather, Patern	al grandmother,	
	Maternal grandfather, Materna Brothers and sisters: (n grandmother	Others: (,
7.1	Brothers and sisters: ()	Others: (,
	(Parental discord, family illness, divorce, financial problems, others())
lf	f yes, please explain in detail.			_
	Tre there any complicated situations as fyes, please explain in detail.	at home right no	ow? (yes/no)	