



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 )

1 0 . 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: ( )

1 1 . 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: ( )

1 2 . 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 ( )

1 3. School life problems

	Period	Details
School absenteeism (yes/no)	_____ ~ _____	_____
Domestic violence (yes/no)	_____ ~ _____	_____
Got bullied (yes/no)	_____ ~ _____	_____
Has trouble with teachers (yes/no)	_____ ~ _____	_____

1 4. 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.