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 <u>is with you</u> 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 <u>or</u> 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.

１５．　At our center, we also offer a "Dental Outpatient Clinic" for children with developmental concerns.Do you have any dental-related concerns?　　　(Yes ・ No)
If yes, please provide details below. (For example: dislikes having a toothbrush in the mouth, cannot stay still, cannot brush themself, etc.)

Would you like to receive a consultation at our center's Dental Outpatient Clinic? (Yes ・ No)

If yes, may we reach out to you with information from our center? (Yes ・ No)