Child's name:_____

Child's date of birth:_____

Dear Parent/Guardian:

Please answer the following questions as best you can, and bring this form in with you on the day of your appointment. If you have any questions about a specific piece of information, do not be concerned. The information will be covered during the appointment.

Thank you.

MEDICAL HISTORY

Child's weight at birth? _____ lbs. _____ oz.

Was your child born full term? Yes No

If not, at what week of gestation? _____ weeks, or

How many _____ weeks or _____ months early?

What type of delivery?

_____ Vaginal delivery (_____ normal/spontaneous _____ Pitocin induced)

_____ Cesarean section – if so, was this due to:
_____ repeat
_____ fetal distress

How old was the mother at the time of delivery? _____ Years

What number pregnancy was this (e.g. 1st, 2nd, etc.)?_____

If any prior pregnancies, how many resulted in a delivery?_____

Hospital where child was born? _____

Was your child adopted? Yes No

If yes, where was your child born?_____

How old was your child when he/she was placed in your care? _____

Was your child conceived through in vitro fertilization? Yes No

Did the mother receive fertility therapy? Yes No

Was your child a singleton or a multiple birth? Singleton Multiple

If a multiple birth, how many children were delivered? _____

What were their birth weights? _____

Were there any maternal medical problems during the pregnancy? Yes No

If yes, what was/were the problem(s)?

_____ Bleeding _____ Diabetes _____ Infection _____ Hypertension

Were any medications taken during the pregnancy? Yes No

If yes, please list medication(s) and reasons taken?_____

_____

_____

Did you have a fetal sonogram? Yes No

If yes, how many?

Result(s) of sonogram(s)? _____ Normal _____ Abnormal

If abnormal, please explain:_____

_____

Was the infant's stay in the nursery:
_____ uneventful _____ complicated

If complicated, please describe:_____

Did the infant leave the hospital with mother after usual post-partum stay? Yes No

Please list any/all operations, hospitalizations (including emergency room visits) and procedures your child has had"

Procedure	When	Why

Has your child had any severe illnesses? Yes No

Illness	When

Has your child had any chronic illnesses, such as ear infections? Yes No

Illness	Frequency	Duration

Is your child currently taking medications? Yes No

If so, please list medications and reason for taking them:_____

_____

_____

Does you child have known allergies to food or medications? Yes No

If yes, please list:_____

_____

Pediatric care is provided by:

Name:_____

Address:_____

Are your child's immunizations up to date? Yes No

Please list any other health care problems:_____

_____

_____

DEVELOPMENTAL HISTORY

Please list the ages at which your child:

Rolled over _____ Sat up _____

Crawled _____ Stood up_____

Cruised _____ Walked alone _____

Said mama/dada _____ Single words _____

2 - word phrases _____

Toilet trained: During the day_____ At night:_____

Please note where your child attended/attends school:

3-year nursery:_____

4-year nursery:_____

Kindergarten:_____

1st grade:_____ 2nd grade_____

3rd grade:_____ 4th grade_____

5th grade:_____ 6th grade_____

7th grade:_____ 8th grade_____

Other:_____

In the current school placement, please indicate the number of students _____,

Teachers:_____, and aides _____

Has your child ever had any of the following evaluations?

	Evaluator	Date	General Findings
Audiology:			
Physical Therapy:			
Speech & Language:			
Psychology:			
Neurology:			
Occupational Therapy:			
Other:			

Has your child received any therapies?

	Frequency	Start Date	End Date

Physical Therapy:_____

Speech & Language Therapy:_____

Occupational Therapy:_____

Other:_____

Describe your child's peer interactions:_____

_____

_____

_____

Child usually goes to sleep at _____ PM

Child does / does not sleep through the night

Child gets up / is wakened at _____ AM

Is your child on a special diet? Yes No

If yes, please describe the diet:_____

_____

_____

_____

FAMILY COMPOSITION

Mother's age__ Occupation _____ Cell Phone _____ Email _____

Mother Name _____

Father's age__ Occupation _____ Cell Phone _____ Email _____

Father's Name _____

Please list the child's siblings:

* Name_____ _____age male / female

* Name_____ _____age male / female

* Name_____ _____age male / female

* Name_____ _____age male / female

* Name_____ _____age male / female

* Name_____ _____age male / female

Do any family members have developmental delays, learning problems or psychiatric difficulties? Yes No

If yes, please explain:_____

_____

_____

_____

_____

_____

_____

_____

Please describe your child and any concerns you have regarding his or her development and behavior

Speech and Language History

What language(s) does your child speak? What is your child's primary language?

What languages are spoken in the home? What is the primary language spoken?

Does your child have a speech or language problem? Yes or No
If yes, describe it.

When was the problem first noticed? By whom?

How does your child communicate (gestures, single words, short phrases, sentences?)

Have any other speech-language specialists seen your child? Who and When? What were their conclusions or suggestions?

Has your child had an Audiological Exam? Please provide date and results?

Are there or has there ever been any feeding problems (e.g., problems with sucking, swallowing, drooling, chewing, different textures, etc.)? If yes, describe.

What Your Child Understands

Describe your child's response to sound:

Does your child react to sounds other than voices? **Yes** **No**

Does your child turn his/her head toward a sound? (e.g., your child may turn his/her head when the telephone rings.) **Yes** **No**

If the object that is making the sound is out of sight, will your child look for the object or towards the directions it is coming from? **Yes** **No**

When someone calls your child's name, does he/she stop what he/she is doing? **Yes** **No**

Does your child look around to find a person who is talking? **Yes** **No**

Does your child put toys in his/her mouth? **Yes** **No**

When you point to a person/object, does your child look at that person/object? **Yes** **No**

When family members extend their hands and say "Come with me," does your child lean forward to go with them? **Yes** **No**

Does your child stop what he or she is doing when someone says "no?" **Yes** **No**

Does your child understand certain words (other than "no") for family members, pets, objects or greetings (for example, your child may raise his or her arms to be lifted when you say "You want up?" or when you say "bye-bye"). **Yes** **No**

If yes, what words does your child understand? _____
_____
_____

Does your child play with more than one toy at a time? (e.g., he or she may play with two toys, such as banging a truck and a cup on the table or pretend to give a drink to a bear with a cup.) **Yes** **No**

Does your child follow simple directions, like "go get your shoe?" **Yes** **No**

Does your child follow directions that have several steps, like "pick up our toys and put them away?" **Yes** **No**

Does your child know what objects are used for (e.g., you drink from a cup and you bounce a ball)? **Yes** **No**

Does your child respond to words like "stop" or "wait?" **Yes** **No**

Does your child understand words for parts of the body? Please circle:

Nose Mouth Eyes Tummy Feet Ears
Hands Head Other_____

Does your child understand the words for clothing? (e.g., does your child raise his or her arms when you say, "Let's put on your coat on?" What words for cloths does our child know? Please circle:

Shoes Socks Pants Shirt Shorts Skirt
Other_____

What Your Child Communicates With You

Does your child make two different vowel sounds, like "a" and "u"? **Yes** **No**
If yes, please identify _____

Does your child make different constant sounds, like "b" and "m"? **Yes** **No**
Circle the sounds your child can make.
P B M N T D K G

Does your child say two sounds together, like "ba" or "bu?" **Yes** **No**
If yes, please identify _____
_____

Does your child wave or greet to say goodbye? **Yes** **No**

Does your child prefer to use words or gestures to let you know what he/she wants? **Yes** **No**

Does your child use words to:

- Ask for something he/she wants to do or request an object **Yes** **No**
- Tell you what he/she is doing **Yes** **No**
- Let you know he/she wants something to happen again **Yes** **No**
- Ask for help **Yes** **No**

- Answer yes/no questions **Yes** **No**

Does your child use question words like “what” or “why?” **Yes** **No**
If yes, please circle:
Who What When Where Why How

How does your child interact with his/her peers (shy, aggressive, uncooperative, etc.)?

Dear Parents/Caregivers,

As part of your child's developmental assessment at The McCarton Center, we ask that you complete the Vineland Adaptive Behavior Scales, Second Edition (Parent/Caregiver Rating Form). Please bring the completed form to your child's first appointment, and it will be reviewed with you at that time.

The Vineland Adaptive Behavior Scales assesses behavior in four domains – communication, daily living, socialization and motor. Each domain has sections. In each section, find the starting point for your child's age. Respond to every item in order, and stop once you have attained a score of "0" on four consecutive items. Some sections do not apply to children younger than 3 years of age. If your child is younger than the age of the first starting point, do not mark any items in that section.

In response to each item, select the best response that characterizes your child's behavior:

- Circle "**2**" if your child usually performs the behavior without help or reminders.
- Circle "**1**" if your child sometimes performs (or partially performs) the behavior without help or reminders.
- Circle "**0**" if your child never performs the behavior or never performs it without help or reminders.
- Circle "**DK**" if you have never seen your child perform the behavior or don't know whether he or she performs it.
- Circle **"N/O"** for No Opportunity when appropriate (an option that is included in some, but not all of the items).

We appreciate your time in filling out this rating form and look forward to meeting with you and your child.

The McCarton Center Psychology Staff