

Albany County Department for Children, Youth and Families
 Comprehensive Evaluation Services
 Child Information

Child's Name: _____ Birth Date: _____
 Age: _____ Sex: _____ Phone: _____
 Mother: _____ Father: _____ Guardian: _____

I. Concerns

- | | | |
|--|----|-----|
| 1. Language Skills (expressive, understanding, articulation)..... | no | yes |
| 2. Cognitive Skills (problem solving, learning)..... | no | yes |
| 3. Fine Motor Skills (stacking blocks, puzzles, pre-writing)..... | no | yes |
| 4. Gross Motor Skills (walking, jumping)..... | no | yes |
| 5. Self-Help Skills (eating, dressing, toileting)..... | no | yes |
| 6. Play Skills (interactions with toys and peers)..... | no | yes |
| 7. Social-Emotional Skills (interactions with peers and adults)..... | no | yes |

II. Prenatal/Neonatal History

- | | | |
|--|-----------|-----|
| 1. Did you have any illnesses during your pregnancy..... | no | yes |
| If yes, explain _____ | | |
| 2. Did you smoke cigarettes during your pregnancy..... | no | yes |
| 3. Did you drink alcoholic beverages during your pregnancy..... | no | yes |
| 4. Was your child born full-term..... | no | yes |
| If no, at approximately how many gestational weeks was your child born _____ | | |
| 5. How much did your child weigh at birth..... | __lbs__oz | |
| 6. Did he/she have trouble starting to breathe..... | no | yes |
| 7. Did he/she have any difficulties while in the hospital..... | no | yes |
| If yes, explain _____ | | |
| 8. Did he/she go home with you when you left the hospital..... | no | yes |
| If no, explain _____ | | |
| 9. If no, how long did he/she stay in the hospital..... | _____days | |

III. Medical History

- | | | |
|---|----|-----|
| 1. Do you have any concerns about your child's hearing..... | no | yes |
| 2. Do you have any concerns about your child's vision..... | no | yes |
| 3. Do you have any concerns about your child's dental health..... | no | yes |
| 4. Has your child had more than 6 colds in one year..... | no | yes |
| 5. Has your child had more than 3 ear infections in one year..... | no | yes |
| If known, how many _____ | | |
| 6. Has your child had the chicken pox..... | no | yes |
| 7. Has your child had the mumps..... | no | yes |
| 8. Has your child had the measles..... | no | yes |
| 9. Has your child had whooping cough..... | no | yes |
| 10. Has your child had pneumonia..... | no | yes |
| 11. Does your child have frequent upper respiratory infections..... | no | yes |
| 12. Does your child have asthma..... | no | yes |

Medical History Continued.....

- 13. Has your child had any seizures..... no yes
If yes, Age_____ Type_____
- 14. Has your child had high lead levels..... no yes
If yes, Age_____ Level_____
- 15. Does your child have allergies..... no yes
If yes, to what_____
- 16. Is your child currently taking any medication..... no yes
If yes, what medication_____ Reason_____
- 17. Has your child had any serious accidents..... no yes
If yes, explain_____
- 18. Has your child ever had to stay overnight in the hospital..... no yes
If yes, reason(s) _____
Age(s) _____ Hospital(s) _____

IV. Developmental History

- 1. At what age did you child roll_____
If uncertain, did your child roll by the age of 6 months..... no yes
- 2. At what age did your child sit independently_____
If uncertain, did your child sit independently by the age of 7 months..... no yes
- 3. At what age did you child crawl_____
If uncertain, did your child crawl by the age of 10 months..... no yes
- 4. At what age did your child stand alone_____
If uncertain, did your child stand alone by the age of 11 months..... no yes
- 5. At what age did your child walk alone_____
If uncertain, did your child walk alone by the age of 15 months..... no yes
- 6. At what age did your child ride a tricycle_____
If uncertain, did your child ride a tricycle by the age of 4 years..... no yes

V. Speech-Language/Hearing History

- 1. Did your child cry a lot as an infant..... no yes
- 2. Could you tell the difference between the cries..... no yes
- 3. Did your child vocalize other than crying by the age of 3 months... no yes
- 4. Did your child babble (e.g. ba-ba-ba) by the age of 6 months..... no yes
- 5. Did your child say “da-da” or “ma-ma” by the age of 9 months..... no yes
- 6. Did your child say 3 or more words (other than da-da or ma-ma)
by the age of 12 months..... no yes
- 7. Did your child say 5-10 words by the age of 15 months..... no yes
- 8. Did your child combine 2 words by the age of 30 months..... no yes
- 9. Did your child combine 3 words or more by the age of 36 months.. no yes
- 10. Does your child speak in an unusually loud voice..... no yes
- 11. Does your child stutter..... no yes
- 12. Do you understand your child..... no yes
- 13. Do other people in your household understand your child..... no yes
- 14. Do people living outside your household understand your child..... no yes
- 15. Is your child understood when speaking, 80% of the time..... no yes

VI. Feeding History

- 1. Did your child have any difficulty sucking as an infant..... no yes
- 2. Does your child have any difficulty swallowing..... no yes
- 3. Does your child have any difficulty chewing..... no yes
- 4. Does your child drool..... no yes
- 5. Does your child eat with a fork or spoon..... no yes
- 6. Does your child drink from a cup..... no yes
- 7. Does your child eat a variety of foods and textures..... no yes
- 8. Would you describe your child to be a picky eater..... no yes

VII. Child Description

- 1. Does your child appear frustrated when he/she is unable to express his/her wants/needs..... no yes
If yes, how is this frustration displayed_____
- 2. Does your child have any nervous habits..... no yes
If yes, explain_____
- 3. Does your child have excessive temper tantrums..... no yes
If yes, describe_____
- 4. Does your child play well with other children..... no yes
- 5. Does your child sleep through the night..... no yes
- 6. Is your child overactive..... no yes
- 7. Is your child's behavior difficult to manage..... no yes

VIII. Toileting Skills

- 1. Does your child wear a diaper during the day..... no yes
- 2. Does your child wear a diaper through the night..... no yes
- 3. Does your child let you know when their diaper is wet or soiled... no yes
- 4. Does your child tell you when he/she needs to use the bathroom... no yes
- 5. Does your child use the toilet independently..... no yes

IX. Family-Social History

- 1. Do any members of your child's immediate family (brothers, sisters, parents, grandparents, aunts, uncles) have speech-language or hearing difficulties..... no yes
who:_____ difficulty:_____
- who:_____ difficulty:_____
- who:_____ difficulty:_____
- who:_____ difficulty:_____
- 2. Do any members of your child's immediate family have learning difficulties..... no yes
who:_____ difficulty:_____
- who:_____ difficulty:_____
- who:_____ difficulty:_____
- who:_____ difficulty:_____

Family-Social History Continued.....

3. Do any members of your child's immediate family suffer from mental illness..... no yes
who: _____ difficulty: _____
who: _____ difficulty: _____
who: _____ difficulty: _____
who: _____ difficulty: _____
4. How many brothers/sisters does your child have living in your home _____
name: _____ age: _____
name: _____ age: _____
name: _____ age: _____
name: _____ age: _____
5. How many brothers/sister does your child have living outside of your home _____
name: _____ age: _____
name: _____ age: _____
name: _____ age: _____
name: _____ age: _____