

**CANTON PUBLIC SCHOOLS**  
**Developmental Information Questionnaire**

Today's Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Child's Nickname (if any): \_\_\_\_\_

Street Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Town: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Mother's Name: \_\_\_\_\_  
(first & last)

Father's Name: \_\_\_\_\_  
(first & last)

Siblings – Names and Ages: \_\_\_\_\_

Other People Living in the Household: \_\_\_\_\_

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Please help us learn more about your child. All the information is confidential and is restricted to professional people directly concerned with your child's education.

**FAMILY INFORMATION**

Any recent births, deaths, divorce, separation, or other major changes in the family? \_\_\_\_\_

Number of places child has lived? \_\_\_\_\_

Has child participated in a preschool program?                      Yes                      No  
If yes, name of school/location: \_\_\_\_\_                      Number of years: \_\_\_\_\_

Please list any organized activities in which your child has been involved (CPAT Play Groups, swim lessons, gymnastics, story hour, etc.) \_\_\_\_\_

Has your child been referred or seen by Birth to Three Services? \_\_\_\_\_

Does any member of your family have a disability? Has any member of your family had any learning problems in school? \_\_\_\_\_

Which languages are spoken at your home (circle all that apply):    English                      Spanish                      Other \_\_\_\_\_

**PRENATAL, BIRTH AND HEALTH HISTORY**

Were there any unusual events during your pregnancy or delivery with this child (for example, toxemia, x-ray treatments, rubella, other maternal illness or injury, drugs, bleeding, amniocentesis or other problems)? \_\_\_\_\_

\_\_\_\_\_

Place of birth: \_\_\_\_\_                      Birth Weight: \_\_\_\_\_                      Was your child premature? \_\_\_\_\_

Did your child have any birth defects or require special care after birth? \_\_\_\_\_

\_\_\_\_\_

List any diagnosis your child has been given concerning the above: \_\_\_\_\_

Describe any serious accidents, illnesses, hospitalizations or surgeries:

Type: \_\_\_\_\_ Date: \_\_\_\_\_ Child's Age: \_\_\_\_\_ Doctor/Surgeon: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has your child had seizures or convulsions? \_\_\_\_\_ When? \_\_\_\_\_

If your child has allergies, please list: \_\_\_\_\_  
\_\_\_\_\_

If your child has a history of frequent colds, ear infections, sinusitis, tonsillitis or chronic cough please describe: \_\_\_\_\_  
\_\_\_\_\_

Food habits (circle all that apply): Eats regularly \_\_\_\_\_ Chews normally \_\_\_\_\_ Swallows normally \_\_\_\_\_ Drools \_\_\_\_\_  
Difficulty sucking or swallowing as an infant \_\_\_\_\_ History of Reflux \_\_\_\_\_

List your child's pediatrician and other specialists who have seen your child:

Name: \_\_\_\_\_ Address: \_\_\_\_\_ Date Seen: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List other agencies that have been involved with your child (clinics, hospitals, physical or occupational therapists, speech therapists, preschools, public health nurses and so on):

Name: \_\_\_\_\_ Address: \_\_\_\_\_ Date Seen: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**GROWTH HISTORY/MOTOR DEVELOPMENT**

If you have concerns about your child's motor development, please explain: \_\_\_\_\_  
\_\_\_\_\_

My child (circle all that apply): seems clumsy \_\_\_\_\_ moves slowly \_\_\_\_\_ falls frequently \_\_\_\_\_  
uses one side of body differently than the other side \_\_\_\_\_ bumps into objects/people \_\_\_\_\_

Is your child: right handed \_\_\_\_\_ left handed \_\_\_\_\_ undetermined \_\_\_\_\_

Which hand does your child use for: drawing tools \_\_\_\_\_ cutting \_\_\_\_\_ eating \_\_\_\_\_

Does your child switch hands? \_\_\_\_\_

At what age (in months) did your child develop hand dominance? \_\_\_\_\_

Age in months (not years) in which the following occurred:

**Motor:**  
Sitting without support \_\_\_\_\_ Creeping on all fours \_\_\_\_\_  
Walking without support \_\_\_\_\_ Walking upstairs with alternating tread \_\_\_\_\_

**Self-help:**  
Dressing self \_\_\_\_\_ Voluntary control of bowels \_\_\_\_\_ Voluntary Control of bladder \_\_\_\_\_  
Independent in toileting \_\_\_\_\_

**Circle all that apply:** can zip \_\_\_\_\_ can tie \_\_\_\_\_ can button \_\_\_\_\_ washes self \_\_\_\_\_ puts on coat \_\_\_\_\_  
drinks from a cup \_\_\_\_\_ eats holding utensils unfisted \_\_\_\_\_

## SPEECH AND LANGUAGE DEVELOPMENT

**Vision:** If you have any concerns about your child's vision, please explain \_\_\_\_\_

Has your child had a recent vision exam? Yes \_\_\_ No \_\_\_ If yes, where was this done and what were the results? \_\_\_\_\_

**Hearing:** If you have any concerns about your child's hearing, please explain \_\_\_\_\_

Has your child had a recent hearing exam? Yes \_\_\_ No \_\_\_ If yes, where was this done and what were the results? \_\_\_\_\_

**Speech and Language:** If you have concerns, please explain: \_\_\_\_\_

At what age (in months) did your child accomplish the following: said first words \_\_\_\_\_  
combined two words together \_\_\_\_\_ spoke in short sentences (ex: I want milk.) \_\_\_\_\_  
Spoke in detailed sentences (ex: I have a red toy that makes noise.) \_\_\_\_\_

My child (circle all that apply):

Began to babble or talk and then stopped    stutters    mouth breather    noisy breather

Comment \_\_\_\_\_

Which is most typical of your child's ability to understand speech? (circle all that apply)  
Does not understand what is said    Understands familiar statements/questions  
Understands very little of what is said    Clearly understands everything said  
Understands what is said when speaker gestures

Which is most typical of your child's ability to communicate? (circle all that apply)  
Uses sentences that are understood by family but not others    Sentences can be understood by others  
Uses speech - primarily single words    Speech is clearly understandable

## SOCIAL AND COGNITIVE DEVELOPMENT

### Social Behavior:

If you have concerns about your child's social interaction, or ability to play by self or with others, please explain: \_\_\_\_\_

My child (circle all that apply):

smiles    laughs spontaneously    separates easily from me    cries often  
makes eye contact    has unusual mannerisms    cries when appropriate

Comments: \_\_\_\_\_

Describe your child's favorite toys and activities: \_\_\_\_\_

Describe how your child plays with toys (for example, length of play, supervised or unattended, pretends with objects): \_\_\_\_\_

Describe how your child plays and generally interacts with other children \_\_\_\_\_

My child (circle all that apply):

- |  |   |
|--|---|
| prefers to play alone                  | is easily upset   |
| prefers to play with one or two others | is easily frustrated                                      |
| plays mostly with brothers or sisters  | is overexcitable  |
| plays with friends own age             | is easygoing  |
| prefers older children or adults       | is generally happy  |
| is usually cooperative                 | is easily angered   |
| is usually difficult                   | stubborn  |
| is usually friendly                    | is afraid of new places and people                        |
| is usually quiet                       | is usually independent                                    |
| usually follows directions             | is able to follow through with a task                     |
| is usually attentive                   | takes turns with others                                   |
| participates in make-believe play      | enjoys being read to                                      |
| reads independently                    | is demonstrative in feeling                               |
| puts nonfood items in mouth            | doesn't like having hair cut or washed                    |
| doesn't enjoy taking a bath            | seems uncomfortable in clothes                            |
| liked to be cuddled as an infant       | sensitive to vibrating sensations                         |
| especially alert to movements          | primarily responsive to objects                           |
| unaware of environment                 | sucks thumbs or fingers, bites nails or chews on clothing |
- requires a lot of your attention \_\_\_ - explain \_\_\_\_\_
- has temper tantrums \_\_\_ - explain \_\_\_\_\_
- fearful \_\_\_ - explain \_\_\_\_\_
- irregular sleeping habits \_\_\_ - explain \_\_\_\_\_

How does your child comfort himself/herself? \_\_\_\_\_

Describe how you discipline your child: \_\_\_\_\_

List any special abilities or interests your child displays: \_\_\_\_\_

Are there any facts you feel are important that are not included above? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name of person completing this form: \_\_\_\_\_

Relationship to child: \_\_\_\_\_