# Beacon Assessment Center

## Developmental Questionnaire

***Please complete prior to your first appointment***

If you would prefer to complete the electronic version of this questionnaire on the Beacon Assessment Center website, please visit http://www.beaconassessmentcenter.com/client-forms/

## CONTACT INFORMATION:

| | | | |
|---|---|---|---|
| Client Name: | | Age: | |
| DOB: | | Grade: | |
| Dates of Evaluation: | | Gender: | M F |
| Language(s) spoken in the home: | | | |
| Name of person completing questionnaire: | | | |
| Relationship to the Child: | | | |
| Father's (or Parent 1) Name: | | | |
| Address: | | | |
| Email Address: | Telephone: | | |
| Mother's (or Parent 2) Name: | | | |
| Address: | | | |
| Email Address: | Telephone: | | |
| Name & Address of Pediatrician: | | | |
| Person who referred child for this evaluation (include relevant titles): | | | |
| Health Insurance: | Policy #: | | |

## REASON FOR REFERRAL:

| |
|---|
| Chief Complaint (include previous diagnoses): |
| Please describe child's strengths: |
| Please describe child's weaknesses: |
| What are you hoping to gain from this evaluation? |

## FAMILY HISTORY:

| | YES | NO | Comments: |
|---|---|---|---|
| Any history of learning challenges (i.e., reading, writing, math) within the family? | | | |
| Any family history of developmental delays (i.e., Autism, intellectual disability)? | | | |
| Any family history of problems with the regulation of attention or behavior? | | | |
| Any neurological or genetic conditions within the extended family? | | | |
| Any family history of mood disorders (i.e., bipolar) or psychiatric conditions (i.e., anxiety, schizophrenia)? | | | |
| Parents marital status: | ___ Married ___ Never Married ___ Divorced/Separated ___ Widowed | | |
| If never married/separated/ divorced, is there joint custody? [Note: If so, both parents need to provide written permission for the evaluation to commence.] | | | |
| Contact with non-custodial parent or custody arrangement if any: | | | |
| Highest level of maternal education: | | | |
| Highest level of paternal education: | | | |
| Was the child adopted? | | | |
| Any history of trauma, abuse, or neglect? | | | |
| Does the child have any involvement with DCF? | | | |
| Contact information for DCF Case Worker: | | | |
| Please describe family composition including people currently living in the home (i.e., siblings ages): | | | |
| Any siblings living outside the home? | | | |
| Any concerns regarding sibling's health, development, learning or behavior? | | | |

## BIRTH HISTORY:

| | YES | NO | Comments: |
|---|---|---|---|
| Complications with this pregnancy? | | | |
| Maternal medications during pregnancy? | | | |
| Units of alcohol consumed per week during pregnancy: | | | |
| Exposure to drugs or other toxins while in utero? | | | |
| Was child born full term? | | | |
| Problems with labor/delivery? | | | |
| Birth weight _____lbs. _____oz. | | | |
| Was child jaundiced? | | | |
| Any other complications noted at birth? | | | |
| Were newborn supports required? | | | |
| Did baby require Intensive Care Nursery? | | | |

## INFANT TEMPERMENT:

| | YES | NO | Comments: |
|---|---|---|---|
| Did child have early feeding challenges? | | | |
| Problems with sleep during infancy? | | | |
| Difficult temperament (i.e., colic or excessive crying)? | | | |
| Did child respond to soothing efforts? | | | |
| Was child passive, shy, withdrawn during the infant or toddler period? | | | |

## MEDICAL HISTORY:

| | YES | NO | Comments (when?): |
|---|---|---|---|
| Any diagnosed genetic or medical conditions? | | | |
| Problems with vision? | | | |
| Concerns about hearing? | | | |
| Date of most recent hearing test: | Results: | | |
| History of ear infections? How Many? | | | |
| Heart defects? | | | |
| History of serious illness? | | | |
| Hospitalizations? | | | |
| Surgeries? | | | |
| Serious injury (i.e., broken bones)? | | | |
| Seizures, convulsions, staring spells? | | | |
| Head injury or loss of consciousness? | | | |
| Allergies? | | | |
| Reflux, constipation, or other gastrointestinal issues? | | | |
| Problems with feeding (i.e. chewing, swallowing) or restricted diet? | | | |
| Problems with sleep (i.e., night waking, night terrors?) | | | |
| Please list all medications that are current. | | | |
| Please list all past medications. | | | |

## DEVELOPMENTAL HISTORY:

| | YES | NO | Comments (When?): |
|---|---|---|---|
| Sat by 8 months? | | | |
| Crawled by 10 months? | | | |
| Walked by 15 months? | | | |
| Problems with motor coordination (i.e., riding a bike, catching a ball)? | | | |
| Hand preference: | ____Right ____ Left ____mixed non-dominance. | | |
| When did handedness emerge? | | | |
| Toilet trained by 3 ½? | | | |
| Night trained by age 5? | | | |
| Did the child have difficulty within the social domain? | | | |
| Did the child show appropriate play skills (i.e., toy play, pretend play, imaginary/fantasy play, cooperative play) | | | |
| Were there behavioral difficulties? (please describe) | | | |
| Did child struggle with the acquisition of early school skills (i.e., learning colors, alphabet, counting)? | | | |

## LANGUAGE HISTORY:

| | YES | NO | Comments (When?): |
|---|---|---|---|
| Babbled by 10 months? | | | |
| Used first word by 12 months? | | | |
| Used two word phrases by 24 months? | | | |
| Used/uses gestures to communicate? | | | |
| Used/uses pictures or symbols to communicate? | | | |
| Child's primary mode of communication: | ___ cries/whines ___ vocalizations ___ AAC<br>___ gestures ___ speech ___Other: | | |
| Does your child have difficulty identifying objects or people by name? | | | |
| Does your child have difficulty understanding what is said to them or following instructions? | | | |
| Does your child have problems naming common objects, people, or events? | | | |
| Does your child have difficulties with expressive language (i.e., forming sentences, answering questions, explaining problems)? | | | |
| Do other people understand your child's speech (i.e., problems with stuttering, articulation)? | | | |
| Does your child initiate or engage in social interactions/conversation with others adults or children? | | | |
| Does your child seem aware of the difficulties they have communicating? | | | |

## SOCIAL/BEHAVIORAL PROFILE:

| Please review the following behaviors and see if they describe your child: | Not True | Sometimes True | Very True |
|---|---|---|---|
| Poor or limited eye contact | | | |
| Does not use gestures or pointing to communicate or share attention | | | |
| Does not use words to express wants and needs | | | |
| Echoes words or repeats phrases | | | |
| Speaks in unusual tone or manner | | | |
| Hard to get child's attention | | | |
| Seems preoccupied, aloof, or distant | | | |
| Repetitive behaviors (e.g., flaps hands, moves body or fingers in unusual way, toe-walks, engages in unusual visual behaviors). Please list any others. | | | |
| Prefers to be alone; ignores others | | | |
| Difficulty relating to peers or making friends | | | |
| Unusual play behaviors; limited pretend play | | | |
| Has unusual or intense interests | | | |
| Takes things overly literally; misses the point or has difficulty with figurative language/idioms/slang | | | |
| Handles change poorly; insists on sameness | | | |
| Sensory Issues (please list) | | | |
| Tantrums/Meltdowns (if yes, how frequent) | | | |
| Difficulties related to Attention/Impulsivity/Overactivity | | | |

## PREVIOUS EVALUATIONS & TREATMENTS:

| School Testing | | |
|---|---|---|
| Date | Grade | Type of Testing (i.e., Psychological, Speech & Language, Occupational Therapy, Educational Testing) |
| | | |
| | | |
| | | |
| | | |
| | | |

| Other Evaluations (i.e., psychologist/neuropsychologist, neurologist, other specialists) | | |
|---|---|---|
| Date | Professional's Name | Results |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

| Medical Tests (i.e., EEG, MRI, Chromosome tests, genetic tests) | | |
|---|---|---|
| Date | Type of Testing | Results |
| | | |
| | | |
| | | |
| | | |

## SERVICE HISTORY:

| Does your child receive any of these services? (Have they in the past?) | YES | NO | If yes, when? |
|---|---|---|---|
| Early Intervention | | | |
| Speech Therapy | | | |
| Occupational Therapy | | | |
| Physical Therapy | | | |
| Special Education Services | | | |
| Repeated a grade? | | | |
| Has child undergone a previous neuropsychological assessment? | | | |
| Existing diagnoses? (Indicate which ones) | | | |
| Has your child been tested by any professionals including school personnel within the last 12 months? | | | |
| Current grade and services (IEP? 504? please describe services): | | | |
| Please list any involved professionals and contact information | | | |
| Psychologist/therapist: | | | |
| Psychiatrist: | | | |
| Advocate: | | | |

**PLEASE ATTACH A CURRENT PHOTOGRAPH OF YOUR CHILD**