cronin
assessment

CHILD DEVELOPMENT INFORMATION

Child's Name: _____ M F Age: _____ Birthdate: _____

Referred by: _____ Specialty: _____ Date: _____

Name of person completing this form: _____

Relationship to child: _____

What languages does the child use (List PRIMARY language first): _____

What other languages is your child exposed to? _____

Other providers have diagnosed my child with: _____

Age of diagnosis/diagnoses: _____

Why do you want your child or relative evaluated? Please check all that apply:

**A**. **DIAGNOSTIC EVALUATION** *because you are concerned about your child's current challenges and need to further understand his or her strengths and difficulties that might include a specific diagnosis.*

**B**. **PROGRAM EVALUATION** *to review your child's educational and community based supports and their effectiveness.*

**C**. **ADVOCACY AND CONSULTATION** *to assist you in identifying and obtaining the support services your child needs.*

*Please check the concerns you have about your child:*

| | | |
|---|---|---|
| aggression | peer relationships | school environment |
| overactivity | language abilities | toilet training |
| preoccupations | temper tantrums | biting |
| hitting | self-injury | sleep problems |
| appetite/food selections | inattentive | self-help skills |
| motor skills | depressed or anxious | medication |

self-stimulatory behaviors: rocking, spinning, flapping hands, visual scrutiny

muscle tone Other: _____

**CHILD'S CURRENT LIVING SITUATION**

With whom does the child currently reside? (please mark all that apply)

| | | | |
|---|---|---|---|
| Biological Mother | Biological Father | Step-mother | Step-father |
| Adoptive Mother | Adoptive Father | Foster Mother | Foster Father |

Other (describe: _____)

Complete the following for the child's BIOLOGICAL PARENTS to the best of your ability, *even if you are not the child's biological parent.*

Biological Mother's name:_____ Age: _____ Birthdate: _____

Occupation: _____ Ethnic/Cultural Background: _____

Work Phone: _____ Home Phone: _____

Biological Father's name:_____ Age: _____ Birthdate: _____

Occupation: _____ Ethnic/Cultural Background: _____

Work Phone: _____ Home Phone: _____

If child does not live with BOTH biological parents, who has legal custody of the child? _____

How often does the other biological parent see this child? _____

Number of years married/together: _____ Approximate date of divorce/separation: _____
Number of times married: Mother _____ Father _____

If the child currently resides with parents OTHER than biological parents, please describe them here.

Parent One's name:_____ Age: _____ Birthdate: _____

Relationship to child: Adoptive Parent Step-Parent Foster Parent Other: _____

Occupation: _____ Ethnic/Cultural Background: _____

Work Phone: _____ Home Phone: _____

Parent Two's Name:_____ Age: _____ Birthdate: _____

Relationship to child: Adoptive Parent Step-Parent Foster Parent Other: _____

Occupation: _____ Ethnic/Cultural Background: _____

Work Phone: _____ Home Phone: _____

Highest level of education by each parent:

| Biological Mother | Biological Father | Parent 1 (above, if app.) | Parent 2 (above, if app.) |
|---|---|---|---|
| 11 grade or less | 11 grade or less | 11 grade or less | 11 grade or less |
| GED | GED | GED | GED |
| High school graduate | High school graduate | High school graduate | High school graduate |
| Associates Degree | Associates Degree | Associates Degree | Associates Degree |
| Bachelor's Degree | Bachelor's Degree | Bachelor's Degree | Bachelor's Degree |
| Graduate/Professional | Graduate/Professional | Graduate/Professional | Graduate/Professional |
| Vocational Certificate | Vocational Certificate | Vocational Certificate | Vocational Certificate |

If child is with ADOPTIVE parent, age child was first in home: _____ Date of legal adoption: _____

What has the child been told about the adoption? _____

If your child spends a significant amount of time with a caregiver other than someone described above (i.e., spends more than 4 hours/day) EXCLUDING school personnel, please complete the following information for that person here:

Caregiver/Nanny/Babysitter: _____Age: _____ Birthdate: _____

Ethnic/Cultural Background: _____ Highest level of education: _____

Occupation: _____

Siblings: (please list whether the siblings live in the child's home or not)

| Name | Age | Sex | Full/Step/Half? | Grade | In child's home? |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

Other occupants of child's residence NOT listed above:_____

**HISTORY**

**Prenatal/Pregnancy**

Did the biological mother have any of the following immediately before/after or during pregnancy?

Maternal injury. Describe: _____

Hospitalization during pregnancy. Reason: _____

X-rays during pregnancy. What month of pregnancy? _____

Did the biological mother have any of the following during pregnancy?

| | | |
|---|---|---|
| Emotional problems | Infections | Premature Labor |
| Rashes | Bed-rest | Toxemia |
| Difficulty in conception | Anemia | Gained more than 35 pounds |
| Excessive swelling | Vaginal bleeding | Measles/German measles |
| Excessive nausea/vomiting | Flu | High blood pressure |
| Kidney disease | Strep Throat | Threatened miscarriage |
| Rh incompatibility | Headaches | Severe cold |
| Urinary problems | Airplane trip during pregnancy | Other virus |
| Special diet, describe: _____ | | Meds: _____ |

Other: _____

Mother's age at conception: _____

Did the mother have previous pregnancies? No Yes, how many, including miscarriages? _____

Did mother receive prenatal care during this pregnancy? No Yes, beginning at month _____

During the pregnancy, was the baby: Very active Average Rather quiet

Were there any unusual changes in the baby's activity level during pregnancy? Yes No

**Delivery**

Was infant born full-term? Yes No

If premature, how early? _____ If overdue, how late? _____

Birth weight: _____ Apgars: at 1 minute _____ at 5 minutes _____

Type of anesthetic used: None Spinal Local General

Length of active labor: _____ Describe any complications during delivery: _____

_____

Check all of the following that applied to the delivery:

| | | |
|---|---|---|
| Spontaneous | Breech | Forceps |
| Head first | Multiple births | Cord around neck |

Induced; Reason: _____

Cesarean; Reason: _____

Which of the following applied to the infant? (check all that apply)

| | | |
|---|---|---|
| Breathing problems | Required oxygen | Required incubator |

Jaundice (Were Bilirubin lights used? No Yes – How long? _____)

| | | |
|---|---|---|
| Feeding problems | Sleeping problems | Infection |
| Rash | Excessive crying | Sleeping problems |
| Seizures/convulsions | Unusual appearance, describe: _____ | |
| Bleeding into the brain | | |

Did the infant require: X-Rays CT scans Blood transfusions

Placement in the NICU (If so, for how long? _____)

Length of stay in hospital: Mother _____ Infant _____

**Developmental History**

During this child's first three years, were any special problems noted in the following areas?

| | | |
|---|---|---|
| Irritability | Breathing problems | Colic |
| Difficulty sleeping | Eating problems | Temper tantrums |
| Failure to thrive | Excessive crying | Withdrawn behavior |
| Poor eye contact | Early learning problems | Destructive behavior |
| Convulsions/Seizures | Twitching | Unable to separate from parent |

Other _____

Milestones. Indicate age when child:

| | | |
|---|---|---|
| _____ sat unaided | _____ crawled | _____ walked |
| _____ started solid foods | _____ fed self with spoon | _____ gave up bottle |
| _____ bladder trained – day | _____ bladder trained – night | _____ bowel trained |
| _____ rides tricycle | _____ rides bike | |

Can child be described as clumsy/uncoordinated? Yes No Having fine motor delay? Yes No

Which hand does your child use for: Writing/drawing? ____ Eating? ____ Cutting? ____

Current eating behavior: Normal Picky Eats too much Weight loss/gain

Oral Motor concerns None Difficulty swallowing Drooling Gagging

**Language development**

Indicate age when child begin babbling, such as repeating syllables, in attempts to communicate?:_____
using single words? _____ using phrases/short sentences? _____

Have there been any hearing concerns? No Yes Hearing testing – date? _____

**Adaptive Skills**

| | | |
|---|---|---|
| Feeds self | No | Yes, beginning at age _____ |
| Dresses self | No | Yes, beginning at age _____ |
| Bathes self | No | Yes, beginning at age _____ |
| Helps with household chores | No | Yes, beginning at age _____ |
| Knows phone number and address | No | Yes, beginning at age _____ |
| Says "please" and "thank you" | No | Yes, beginning at age _____ |
| Tells time accurately | No | Yes, beginning at age _____ |

Has the child ever lost skills, which at one time he/she was able to perform? No Yes

If yes, please explain _____

When your child is disruptive or misbehaves, what steps are you likely to take to deal with the problem?

Time out Loss of allowance/privileges Physical punishment Yelling
Ignoring Grounding Other, describe _____

Who is mainly in charge of discipline? _____

What do you find most difficult about raising your child? _____

_____

**Family Changes and Stressors:** Please indicate any major family stresses the family and/or child is currently experiencing or has experienced within the last year.

| | | |
|---|---|---|
| Marital discord/fighting | Separation | Divorce |
| Birth/Adoption of another child | Sibling conflict | Parent-Child conflict |
| Custody disagreement | Single-parent family | Parent/sibling death |
| Parent deployed extensively | Parent emotionally/mentally ill | Involved in juvenile court |
| Abandonment by parent | Financial problems | Parent substance abuse |
| Child Neglect | Physical abuse | Sexual abuse |

Parental disagreement about child-rearing Involved with Social Services/Child Protective Services
Other, if not listed: _____

**Family History**

Have any members of the biological mother's or biological father's families had any of the following problems or disorders (check all that apply):

| | | |
|---|---|---|
| Birth Defect | Chromosomal/genetic disorder | Obsessive Compulsive Disorder |
| Cerebral Palsy | Severe head injury | High blood pressure |
| Kidney disease | Migraine headaches | Multiple Sclerosis |
| Physical handicap | Nervousness/Anxiety | Stroke |
| Tuberous Sclerosis | Alzheimer's disease | Hemophilia |
| Huntington's chorea | Muscular dystrophy | Parkinson's disease |
| Sickle-cell anemia | Cancer | Seizures/epilepsy |
| Diabetes | Heart disease | Food allergies |
| Alcohol/drug abuse | Depression | Physical/Sexual abuse |
| Schizophrenia | Mental Retardation | Speech/language delay |
| Autism/PDD | Reading problem | Other learning disability |

Emotional disturbance/mental illness Bipolar/manic-depressive disorder
Tics/Tourette's syndrome Antisocial Behavior (assaults, thefts, arrests, etc.)
Childhood behavior disorder (aggressive/defiant/ADHD) Other: _____

Has anyone in the family ever received special education services? No Yes - for what reason?

**Checklist:** Please mark any of the following in each area that describe *your child* currently or in the past:

**Speech**

| Past | Current | | Past | Current | |
|---|---|---|---|---|---|
| | | slow speech development | | | doesn't understand without gestures |
| | | unusual tone or pitch | | | repeats words/phrases over and over again |
| | | difficult to understand speech | | | repeats questions, instead of answering them |
| | | seldom speaks unless prompted | | | repeat dialogue from movies or songs verbatim |
| | | has language of his/her own (may sound like foreign language/jargon) | | | |

**Relating with other people**

| Past | Current | | Past | Current | |
|---|---|---|---|---|---|
| | | prefer to be by self | | | "in a world of his/her own" |
| | | aloof, distant | | | cling to people |
| | | fearful of strangers | | | not cuddly as baby |
| | | doesn't like to be held | | | doesn't recognize parent |
| | | fearful of strangers | | | doesn't play with other children |
| | | prefers playing with younger or older children | | | |

**Imitation**

| Past | Current | |
|---|---|---|
| | | doesn't imitate waving "bye-bye" or "patty cake" etc. (physical imitation) |
| | | doesn't repeat words/things said to him |
| | | doesn't repeat words generally**,** but usually did what he was asked to do |

**Response to Sounds, Speech**

| Past | Current | | Past | Current | |
|---|---|---|---|---|---|
| | | often ignores sounds | | | often ignores what is said to him/her (speech) |
| | | afraid of certain sounds | | | really likes certain sounds (music, motors, etc.) |
| | | seems to hear distant or soft sounds that most other people don't hear or notice | | | |
| | | unpredictable response to sounds (sometimes reacts, sometimes doesn't) | | | |
| | | responds to speech and sounds like other children of the same age | | | |

**Visual Response**

| Past | Current | | Past | Current | |
|---|---|---|---|---|---|
| | | stares vacantly around room | | | plays with turning lights on and off |
| | | often doesn't look at things | | | distracted by lights – stares at certain lights |
| | | likes to look at self in mirror | | | very interested in small parts of an object |
| | | likes to look at shiny objects | | | looks at things out of the corners of eyes |
| | | stares at parts of his/her body (e.g. hands) | | | |
| | | often avoids looking at people when they are talking to him | | | |

**Other Senses**

| Past | Current | | Past | Current | |
|---|---|---|---|---|---|
| | | puts many objects in mouth | | | likes vibrations |
| | | licks objects | | | doesn't notice pain as much as most people |
| | | overreacts to pain | | | smell objects unusual or unfamiliar objects |
| | | chew or eat objects that are not supposed to be eaten | | | |

**Emotional Responses**

| Past | Current | | Past | Current | |
|---|---|---|---|---|---|
| | | temper tantrums | | | laughs/smiles for no obvious reason |
| | | overly responds to situations | | | moods change quickly/for no apparent reason |
| | | cries/seems sad for no obvious reason | | | often has blank expression on face |
| | | little response to what is happening around him | | | |

**MEDICAL HISTORY**

Has your child ever had:

Head injury Age _____ Describe _____

Loss of consciousness - Age ____ How long? _____ Describe_____

Allergies to food/medication List: _____

Surgery - Age_____ Reason _____ Describe_____

Ear Infections: Age ____ Describe _____

Is the child up to date on immunizations? Yes No, Why not? _____

_____

**Doctors seen** (check all that apply)

Pediatrician – Date of last visit: _____ Diagnosis: _____

Developmental Pediatrician – Date: _____ Diagnosis: _____

Neurologist – Date: _____ Diagnosis: _____

suspected seizures, describe: _____

seizures diagnosed, type: _____

Genetics – Date: _____ Diagnosis: _____

Psychiatry – Date: _____ Diagnosis: _____

Ongoing Treatment? Yes No. _____

Psychologist- Date: _____ Diagnosis:_____

Ongoing Treatment? Yes No. _____

Gastroenterology – Date: _____ Diagnosis: _____

stomach/intestinal problems, type: _____

Endocrinology – Date: _____ Diagnosis: _____

**Diagnostic Testing** (check all that apply)

EEG (brain wave test) – Date: _____ Results: _____

MRI – Date: _____ Results: _____

CT Scan – Date: _____ Results: _____

Ophthalmology Evaluation – Date: _____ Results: _____

Chromosomal/DNA testing (Genetic) – Date: _____ Results: _____

Other - Describe: _____

**Medication history**

CURRENT medications **(PLEASE NOTE: DO ADMINISTER your child's regularly scheduled medications, if any, on the day of each appointment.)**

Name of medication Dose & Frequency Date Started Reason Effectiveness

_____

_____

_____

Who prescribes these medications? _____ Date of last visit: _____

Please also list any medications your child has been on in the PAST:

Name of medication Dose & Frequency Date Started & Ended Reason Effectiveness

_____

_____

_____

_____

Who prescribed past medications? _____

**SCHOOL HISTORY**

(If more space is necessary, please attach additional sheets or write on the back of this page.)

Current school:_____ School district:_____

Grade level: _____ Type of class: Regular Ed Special Ed SDC ED RSP

Current # of: Students ____ Teachers ____ Aides ____ Does your child have a 1:1 Aide? _____

Has your child had special education testing in school?

Psychological/Cognitive – Date: _____ Academic – Date: _____
Speech/Language – Date: _____ Other: _____ Date: _____

Is your child receiving any special education services at school? Yes No

Is your child on an IEP (Individual Education Plan) or have a 504 Plan? _____

For what reason? _____

Please list all of the schools, including preschools, your child has attended:

Name of school Age/grade attended Hours per day Days per week

_____

_____

_____

_____

_____

_____

**SERVICES** - Please list services your child has received.

**School District (Please bring copies of your most recent Individual Education Plan (IEP))**

Child's age when school services began: _____

Individual Education Plan (IEP) eligibility: _____

Which services is your child CURRENTLY receiving through the SCHOOL DISTRICT?

| | | |
|---|---|---|
| Speech therapy | Occupational therapy | Physical therapy |
| Adaptive Physical Education | Discrete Trial Training (DTT/ABA) | Social Skills |

Other - describe: _____

_____

**Regional Center**: **(Please bring copies of your most recent Regional Center assessment Individual Family Service Plan (IFSP), and relevant reports to your appointment.)**

Is your child currently a client of the Regional Center? Yes No (skip to Private Services)

Which Regional Center: _____ Eligibility category: _____

Child's age when Regional Center services began: _____

Which services is your child CURRENTLY receiving through the REGIONAL CENTER?

| | | |
|---|---|---|
| Speech therapy | Occupational therapy | Physical therapy |
| Adaptive Physical Education | Discrete Trial Training (DTT/ABA) | Social Skills |

Other - describe: _____

_____

**Private Services (Please bring copies of relevant reports to your first appointment.)**

Are you or your insurance companies currently paying for services to address your child's needs? Yes No

| | | |
|---|---|---|
| Speech therapy | Provided by: _____ | Age when began: _____ |
| Occupational therapy | Provided by: _____ | Age when began: _____ |
| Physical therapy | Provided by: _____ | Age when began: _____ |
| Adaptive Physical Education | Provided by: _____ | Age when began: _____ |
| Social Skills | Provided by: _____ | Age when began: _____ |
| Discrete Trial Training (DTT/ABA) | Provided by: _____ | Age when began: _____ |

Other - describe: _____

_____

**Extracurriculur Activities**: Please list any after-school activities, summer camps or programs, or other classes or recreational activities that your child has participated in during the past year:

Program Name; dates attended/days per week/hours per day; number in group

**For example: Karate; July-Dec 2010, 3 days week**

_____

_____

_____

_____

_____

_____

**Please SEND or BRING copies of the following:**

**Most recent Individual Education Plan (IEP),**

**Regional Center assessment or Individual Family Service Plan (IFSP)**

**Assessment reports by psychologists or school personnel**

**Any other relevant reports**

**This completed appointment packet information**

**Any questionnaires that were sent to you.**