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 your 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:_____