ACHIEVE! CENTER, INC.

ACHIEVE CENTER (Child)

Client_____ DOB_____
(first) (MI) (last)

Gender ☐ Male ☐ Female Ethnicity: _____

Mailing address_____ City_____State_____ Zip _____

Telephone Home_____ Work_____ Cell_____

May we contact you at home? ☐ yes ☐ no At work? ☐ yes ☐ no On your cell? ☐ yes ☐ no

Person financially responsible_____**Social Security Number**_____

Relationship to client_____ Home phone_____

Address_____ City_____State_____ Zip_____

Parent (mother)_____ DOB_____

Mother's Social Security Number_____

Address_____ City_____State_____ Zip_____

Employer_____ Business Phone_____

Mother's Phone Number_____

Mother's Email Address _____

Parent (father)_____ DOB_____

Father's Social Security Number_____

Address_____ City_____State_____ Zip_____

Employer_____ Business Phone_____

Father's Phone Number _____

Father's Email Address _____

Who is legally responsible for child?_____

With whom does the child reside?_____

Referral Source_____

Emergency Contact_____ Phone_____

Primary Care Physician and Clinic_____

INSURANCE INFORMATION

Primary Insurance Name_____

Policyholder Name_____ Policyholder DOB_____

Member ID Number_____ Group #_____ Insurance Phone #_____

Secondary Insurance Name_____

Policyholder Name_____ Policyholder DOB_____

Member ID Number_____ Group #_____ Insurance Phone #_____

We ask for your social security number only because it is required by insurance providers

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DEVELOPMENTAL ASSESSMENT QUESTIONNAIRE

Birth to Age 3

Important

If a question does not apply, write N/A. If you do not know the answer, write DO NOT KNOW.
Note: The information you provide is confidential and protected by law.

Date: _____

Demographic Information

Child's name:_____ Date of Birth: _____ Age: _____Gender: ☐ Male ☐ Female

Who referred you:_____

Concerns you may have regarding your child's development: _____

_____

_____

DEVELOPMENTAL HISTORY

Mother's age at time of the child's birth: _____ **Father's age at time of the child's birth:** _____

Was your child possibly exposed to alcohol, nicotine or other substances during mother's pregnancy? ☐ Yes ☐ No

What were the complications or concerns during the pregnancy for the mother? ☐ None
(If any of the following occurred, please elaborate on condition/treatment.)

☐ Gestational diabetes ☐ Anemia ☐ Preeclampsia ☐ Placenta previa ☐ Toxemia ☐ Depression
☐ Sexually transmitted disease ☐ Heart disease ☐ Physical trauma ☐Premature labor☐ Abuse
☐ Other: _____ ☐ Prescribed medications: _____

Was bed rest required? ☐ No ☐ Yes
If yes, please describe timeframe and reason:_____

Length of Pregnancy

☐ Full term ☐ Premature – born at how many weeks? _____ Birth weight _____
Place of Birth ☐Hospital name _____ ☐ home ☐other

Was labor induced? ☐ No ☐ Yes, please describe the reason:_____
Length of labor _____ **Length of time pushing** _____

Mode of delivery: ☐ Vaginal ☐ Cesarean ☐ Emergency Cesarean
How many days was the baby in the hospital? _____
Were there any concerns or complications during/immediately following your delivery?

☐ Baby's heart rate dropped ☐ Cord wrapped around neck/umbilical cord
☐ Born "blue" ☐ Breech ☐ IV fluids ☐ General concerns about the baby's overall physical appearance
☐ Low Apgar scores of _____ ☐ Significant jaundice (bilirubin) ☐ Oxygen
☐ Difficulty sucking ☐ Low blood sugar
☐ Treatment in the NICU – details: _____

Temperament as an infant: ☐ Easy ☐ Withdrawn ☐ Difficult to calm ☐ Other:_____

Bonding: ☐ Cuddly ☐ Withdrawn ☐ Clingy ☐ Other:_____

Activity level as an infant: ☐ Average ☐ On-the-go ☐ Destructive ☐ Lethargic ☐ Accident prone

Apprehension with strangers: ☐ Mild ☐ Moderate ☐ Severe ☐ None

Emotionally oversensitive/over-reactive as an infant: ☐ No ☐ Yes
Does this continue to be a problem? ☐ No ☐ Yes

Developmental milestones (check all that apply):

By 2-4 Weeks:

☐ Can sleep for 3 or 4 hours at a time
☐ Responds to parent face/voice
☐ Searches for parent's face
☐ On stomach, lifts head momentarily
☐ Can stay awake for >1 hour
☐ When crying, can be consoled most of the time, by being spoken to or held

By 2 Months:

☐ Coos/vocalizes
☐ Smiles responsively
☐ Lifts head, neck, and upper chest w/support of forearms from stomach

By 9 Months:

☐ Responds to name
☐ Understands a few words
☐ Babbles
☐ Reaches for objects
☐ Crawls, creeps, or scoots
☐ Sits unsupported
☐ Plays peek-a-boo or pat-a-cake
☐ Pokes with fingers, shakes, bangs, throws, drops objects
☐ Feeds self with fingers

By 12 Months:

☐ Pulls to stand and may take a few steps alone
☐ Drinks from cup
☐ Says 2-4 words, imitates vocalizations
☐ Looks for dropped or hidden objects
☐ Steps while holding on
☐ Waves "bye-bye"
☐ Feeds self
☐ Brings toys/object to show

By 18 Months:

☐ Walks backward
☐ Throws ball
☐ Scribbles
☐ Uses two-word phrases
☐ Uses a spoon and cup
☐ Shows affection, kisses
☐ Follows simple directions
☐ Points to some body parts
☐ Pulls a toy along the ground
☐ Watches face for reaction

By 24 Months:

☐ Goes up and down stairs one step at a time
☐ Kicks ball
☐ Stacks five blocks
☐ Uses at least 20 words, two-word phrases
☐ Follows two-step commands
☐ Imitates adults

MEDICAL HISTORY

Date of last physical examination: _____ **Name of Physician:** _____

Purpose of physical examination: _____

Name of primary care physician & clinic name: _____

☐ **Major Surgery** (attach additional information/list if needed):

Procedure: _____

Age: _____
☐ No complications
Complications: _____

Procedure: _____

Age: _____
☐ No complications
Complications: _____

☐ **Medical Hospitalization** (attach additional information/list if needed):

Cause: _____ Cause: _____

_____ _____

_____ _____

Dates/Age: _____ Dates/Age: _____

☐ **Medical Diagnoses:**

1.
2.
3.
4.
5.
6.

Has the child ever experienced the following? If yes, please elaborate below.

☐ High fever requiring hospitalization or treatment: _____

☐ Unexplained fever or spike of temperature: _____

☐ Head injury: _____

☐ Concussion: _____

☐ Loss of consciousness: _____

☐ Seizures Type: ☐ Partial ☐ Partial complex ☐ Generalized

Beginning at what age: _____ Frequency: _____

☐ Tics or abnormal body movements: _____

☐ Thyroid or endocrine problems

☐ Chronic ear/sinus infections Were tubes required? ☐ No ☐ Yes, at what age(s): _____

☐ Strep throat ☐ Diabetes/blood sugar problems ☐ Meningitis, encephalitis

☐ Bronchitis, pneumonia ☐ Upper respiratory problems/asthma

☐ Other congenital conditions: _____

☐ Lead or other toxin exposure: _____

Please list currently prescribed medications:

	Medication	Dose	Frequency	Prescribing Physician
1.				
2.				
3.				
4.				
5.				

Past medications that have produced a negative reaction/ineffective medications:

	Medication	Dates used	Reason for Discontinuation
1.			
2.			
3.			
4.			
5.			

Current Medical Conditions/Illnesses
Hearing: ☐ No problems ☐ Conductive impairment ☐ Sensory-neural impairment ☐ Hearing devices
Vision: ☐ No problem ☐ Nearsighted ☐ Farsighted ☐ Glasses ☐ Contacts ☐ Blind ☐ Other:_____
Speech: ☐ No problem ☐ Does not speak ☐Speaks words, no sentences ☐ Words difficult to understand ☐ Stutters

Current Sleep
☐ Duration in hours: _____ ☐ Requires naps ☐ Midnight awakening ☐ Early awakening
☐ Difficulty falling asleep ☐ Other: _____
☐ Nightmares ☐ Frequency: _____ per week ☐ Content:_____
How handled: _____
_____

Eating
☐ No problems ☐ Obsessed with food – since:_____ ☐ Increased/decreased appetite – since:_____
☐ Weight gain/loss Amount in pounds: _____ Since: _____
☐ Drooling ☐ Food falls from mouth ☐Gags ☐ Eats limited types of food ☐ Has taste/texture sensitivities
☐ How handled: _____

Allergies: ☐ No ☐ Yes **Diagnosed by:** _____

Describe: _____

How Treated:_____

Swallowing Problems: ☐ yes ☐ no
Describe:_____

How Handled:_____

Special Diet: ☐ yes ☐ no
Describe:_____

Speech/Language:

Allied health professional(s)

	Name	Time Frame/Dates of Treatment
Speech/Language		
Occupational Therapy:		
Physical Therapy:		
Birth to Three:		
Neurologist(s):		
Other:		

Verbal Skills:

Is your child verbal?: ☐ Yes ☐ No
If verbal, at what age did your child begin using: 1 words? _____ sentences?_____

Delay in verbal response: ☐ Yes ☐ No

Describe:_____

Becomes frustrated with self-expression: ☐ Yes ☐ No

Describe:_____

Uses speech/language assistance devices: ☐ Yes ☐ No

Describe:_____

Can use words to express needs/wants: ☐ Yes ☐ No

Describe:_____

Can pronounce words correctly: ☐ Yes ☐ No

Describe:_____

Can imitate others verbalizations: ☐ Yes ☐ No
Which Verbalizations?: _____
Will attempt conversational turns with parents when engaged?:_____
_____

MOTOR SKILLS:
Please describe your child's gross motor skills (e.g. running, jumping, catching a ball, etc.):_____

_____

_____

Please describe your child's fine motor skills (e.g. holding a crayon, holding a spoon, staying in line when coloring, etc): _____

_____

SKILLS AND ABILITIES:

Knows colors: ☐ Yes ☐ No ☐ All ☐ Some
Which colors if some known?: _____

Knows letters: ☐ Yes ☐ No ☐ All ☐ Some
Which letters?: _____

Knows numbers: ☐ Yes ☐ No ☐ All ☐ Some
Which numbers?: _____

Can count: ☐ Yes ☐ No
How high?: _____

Knows shapes: ☐ Yes ☐ No
Which shapes?:_____

Can identify objects: ☐ Yes ☐ No
Which objects?: _____

Can point to objects: ☐ Yes ☐ No
Which objects?: _____

Can imitate other actions: ☐ Yes ☐ No
Which actions?: _____

Can do puzzles: ☐ Yes ☐ No
How big of puzzles?: _____

Behaviors

Does your child have any of the following behaviors?
Aggression towards property: ☐ Yes ☐ No

Describe:_____

Triggers:_____

Frequency:_____

Reduction strategies:_____

Aggression behaviors toward self: ☐ Yes ☐ No

Describe:_____

Triggers:_____

Frequency:_____

Reduction strategies:_____

Aggression towards others: ☐ Yes ☐ No

Describe:_____

Triggers:_____

Frequency:_____

Reduction strategies:_____

Self stimulation: ☐ Yes ☐ No

Describe:_____

Triggers:_____

Frequency:_____

Reduction strategies:_____

Avoidance: ☐ Yes ☐ No

Describe:_____

Triggers:_____

Frequency:_____

Reduction strategies:_____

Obsessions/Repetitive Behaviors: ☐ Yes ☐ No

Describe:_____

Diversion Technique:_____

Meltdowns: ☐ Yes ☐ No

Describe:_____

Triggers:_____

Reduction strategies_____

Sensory Sensitivites:

Please describe any known or suspected sensory issues - sensitivities:_____

_____

SUBSTANCE ABUSE

Please indicate any substance used currently or in the past by parent:

Current	Past		mother	father
☐	☐	Alcohol	☐	☐
☐	☐	Marijuana	☐	☐
☐	☐	Ecstasy	☐	☐
☐	☐	Huffing (gas, aerosol, etc.)	☐	☐
☐	☐	Cocaine	☐	☐
☐	☐	Methamphetamine	☐	☐
☐	☐	Heroin	☐	☐
☐	☐	Other	☐	☐

Was your child exposed to a substance during pregnancy? Explain: _____

_____

FAMILY

Current Living Situation

☐ Biological parents (married or cohabitating)
☐ Biological parents (divorced/separated) ☐ shared placement ☐ with visitation ☐ without visitation
☐ Biological mother and stepfather/ partner ☐ shared placement ☐ with visitation ☐ without visitation
☐ Biological father and stepmother/ partner ☐ shared placement ☐ with visitation ☐ without visitation
☐ Adoptive parents
☐ Foster family

☐ Other: _____

Placement/Visitation Schedule: _____

Name of mother: _____ DOB: _____ Employer: _____ Position: _____

Name of father _____ DOB:_____ Employer:_____ Position: _____

Date of marriage:_____ Date of divorce (if applicable): _____

Mother's highest education level:_____ Father's highest education level: _____

Name of stepmother / partner: _____ DOB: _____ Occupation: _____

Name of stepfather / partner:_____ DOB: _____ Occupation: _____

Names of siblings	Living in the home	DOB	Quality of Relationship
_____	Y N	_____	☐ Good ☐ Fair ☐ Poor
_____	Y N	_____	☐ Good ☐ Fair ☐ Poor
_____	Y N	_____	☐ Good ☐ Fair ☐ Poor
_____	Y N	_____	☐ Good ☐ Fair ☐ Poor
_____	Y N	_____	☐ Good ☐ Fair ☐ Poor

Names of stepsiblings	Living in the home	DOB	Quality of Relationship	From mother's Marriage (check)	From father's marriage (check)
_____	Y N	_____	☐ Good ☐ Fair ☐ Poor	☐	☐
_____	Y N	_____	☐ Good ☐ Fair ☐ Poor	☐	☐
_____	Y N	_____	☐ Good ☐ Fair ☐ Poor	☐	☐
_____	Y N	_____	☐ Good ☐ Fair ☐ Poor	☐	☐
_____	Y N	_____	☐ Good ☐ Fair ☐ Poor	☐	☐
_____	Y N	_____	☐ Good ☐ Fair ☐ Poor	☐	☐

Other important persons in the child's life:

Name	Age	Nature of Relationship to Child	Quality of Relationship
_____	_____	_____	☐ Good ☐ Fair ☐ Poor
_____	_____	_____	☐ Good ☐ Fair ☐ Poor
_____	_____	_____	☐ Good ☐ Fair ☐ Poor
_____	_____	_____	☐ Good ☐ Fair ☐ Poor

FAMILY HISTORY QUESTIONS

Does anyone on either the mothers side or fathers side of the family have had or are suspected to have had difficulties with any of the following: (please check which side of family)

		Mother's Side	Father's Side
Attention	Who:	_____	_____
Learning Difficulties	Who:	_____	_____
School Problems	Who:	_____	_____
Behavior Problems	Who:	_____	_____
Depression	Who:	_____	_____
Anxiety	Who:	_____	_____
PTSD	Who:	_____	_____
Drug/Alcohol abuse	Who:	_____	_____
Legal issue	Who:	_____	_____
Hallucinations/delusions	Who:	_____	_____
Bipolar/depression	Who:	_____	_____
Eating	Who:	_____	_____
Epilepsy	Who:	_____	_____
Mental Retardation	Who:	_____	_____
Dementia, Alzheimers	Who:	_____	_____
Traumatic Brain Injury	Who:	_____	_____
Autism, Aspergers	Who:	_____	_____
Heart or lung problems	Who:	_____	_____
Speech/Language problems	Who:	_____	_____
Genetic Disorders	Who:	_____	_____

Significant Trauma (include age at time of incident, nature of trauma, and any legal details)

☐ Injured in an accident: _____

☐ Physical abuse (child was the ☐ victim ☐ perpetrator): _____

☐ Sexual assault/abuse (child was the ☐ victim ☐ perpetrator): _____

☐ Emotional abuse (child was the ☐ victim ☐ perpetrator): _____

☐ Neglect: _____

☐ Removed from home ☐ Foster care ☐Residential treatment ☐ Parent or other removed from home

Losses/separations (deaths, moves, etc.): _____

_____

SOCIAL RELATIONSHIPS

What words best describe the child?

- ☐ Friendly
- ☐ Interested in watching others
- ☐ Makes eye contact when spoken to
- ☐ Withdraws
- ☐ Socially awkward with other children
- ☐ Interested in friends
- ☐ Enjoys playing with others
- ☐ Shy
- ☐ No social opportunities
- ☐ Not interested in friends
- ☐ Easily distressed with others

How does your child adjust to separating from parent, being next to other children, among people child does not know (participation in group activities, sharing, playing with other children, etc.)**?** _____

_____

_____

DISCIPLINE

Physical: ☐ Spanking ☐ Other: _____

Non-physical: ☐ Time outs ☐ Yelling/screaming ☐ Taking things away ☐ Praise ☐ Distraction

☐ Other: _____

Child's response to discipline: _____

What are the child's greatest strengths/attributes? _____

_____

Additional information you would like to let the clinician know (state your primary concerns regarding your child):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Completed by Parent/Guardian: _____ **Date:** _____

Specialist: _____ **Date:** _____