Nursing Checklist and Development and Life Experiences Form

***CHILD DEVELOPMENT and FAMILY LIFE EXPERIENCES**

Please return the completed form to: CSHCN, Box 144710, SLC UT 84114-4710 Attn: ABLE Program

Today's Date_____

Child's Name_____ **DOB**_____ **Age**_____

Parent(s') Name(s)_____ **Age(s)**_____

Address_____

Length of time at this address_____

Phone Number(s) Home: _____ **Work:** _____

Languages (other than English) spoken in home_____

Ethnic, cultural affiliation_____

Year Parent(s) Received High School Diploma, GED_____

Other Education_____

Years Married or Living With Present Spouse or Partner_____

Ages at start of current relationship_____

Child's Physician's Address_____ **Ph#**_____

Other Healthcare Provider_____ **Ph#**_____

Number of Other Marriages or Partner Relationships_____

In order to evaluate and address possible reasons which may be contributing to the difficulty your child is experiencing in school or preschool, we would like you to assist us by <u>answering the following questions honestly and to the best of your ability.</u> <u>Some of the questions will not be applicable to your child because of never having had an opportunity to learn that task.</u> This questionnaire will become a permanent and CONFIDENTIAL part of your child's chart. The accuracy of this history will determine the kinds of appointments and future scheduling for your child.

Please describe concerns about your child_____

_____

_____

_____

_____

Mother's Employment_____ **How long?**_____ **Satisfied?**_____

Number of Jobs Mother has had in the last three years_____

Father's/partner's Job_____ **How Long?**_____ **Satisfied?**_____

Number of Jobs Father/partner has had in the last three years_____

1. <u>Physical Health</u>

a. <u>Pregnancy</u> *(Mark with an X <u>only if statement is true or mostly true.</u> You may want to add qualifying information beside each statement)*

_____I had problems with the pregnancy, labor, or delivery of my child. **(circle)**

Month started prenatal care 1-3 4-6 7-9 **(Circle)**

_____My baby had complications after delivery; number of days (weeks) in hospital (due to prematurity, bleeding in the brain, on a respirator, infection, jaundice, other). **(circle)**

What was your child's birth weight?_____

_____My baby was slow to gain weight as an infant.

_____My baby didn't thrive.

Please **(circle)** the following which applied during the pregnancy: I

smoked cigarettes was depressed drank beer, alcohol

used drugs or substances was physically sick was stressed out

took medication was physically or emotionally hurt

b. Hereditary Life Events of the Parent(s)/Relative(s)--NOT the Child

Initial the following blanks as they pertain "M" to MOTHER of child, "F" to FATHER of child, or "R to RELATIVES in the family.

_____neurological condition(s)

_____seizures

_____serious illness **(Explain)**

_____receiver of harsh discipline

_____adoption

_____accidents **(Explain)**_____

_____long term medication for any condition

_____drug use

_____smoking

_____trouble with the law

_____court

_____multiple hospitalizations **(Explain)**

_____depression

_____trouble in school

_____trouble with learning

_____failure to graduate from high school

_____jail/prison

_____abuse: **(circle)** sexual/emotional/physical

_____alcohol use

_____multiple relationships, marriages

_____divorce

_____birth defects_____

_____other hereditary disorders

_____other mental or physical problems **(Explain)**

_____

Please list all adults and children in your household:

Name Age	Relation to child	Mark X if there is a problem in how well person is doing in each area and please explain: Family	School	Work/Play	Friends	Health	Mental Health	Physical Health	
_____									
_____									
_____									
_____									
_____									

c. **Child's Health** *(Mark with an X only if statement is true or mostly true.*
You may want to add qualifying information beside each statement)

My child...

_____has trouble with vision/wears glasses.

_____has poor hearing.

_____has history of many ear infections.

_____has/had a lot of sickness.

_____has a poor appetite, is picky, or has a feeding problem.

_____has nightmares/talks, is noisy, moves in sleep.--

_____has difficulty sleeping, going to bed, staying asleep, getting up.--

_____is overweight.

_____has/had seizures.

_____has a lot of eye blinking or redness.

_____smacks lips or blinks eyes frequently.

_____sweats too much.

_____has tics, tremors or odd movements.

_____hums; has disturbing vocal sounds.

_____is weak.

_____is often tired.--

_____isn't growing or gaining weight.

_____smokes, drinks, uses drugs **(circle)**

_____had/has a head injury of any kind.

_____has staring spells, is spacy or seems to daydream a lot.

_____has frequent headaches and/or stomach aches, or other body pain.**(circle)**--

_____has/had asthma or chronic cough.

_____soils and/or wets day and/or night.

_____has been on long-term medication.

_____has had surgeries or serious medical problems.**(Explain)**

_____

_____has allergies and/or rashes **(circle)**

_____is accident prone. (Number of serious cuts needing sutures:_____)

_____uses right/left hand over the other, or uses both hands equally. **(circle)**

_____eats a lot of one particular food such as: sugar, sodas, water, milk, salt, and wheat. **(circle)**

_____has dental problems.

_____has frequent extreme temper tantrums which aren't appropriate to the cause.

2. Temperament/Sensitivities *(Mark with an X only if statement is true or mostly true.)*

My child...

_____had/has rocked, banged his/head, or has other unusual postures or mannerisms.

_____had/has a strong choice to avoid certain

_____is irritable--

_____avoids trying new physical tasks.

food textures.

_____is over/under-sensitive to temperature, odor, touch, pain, light. **(circle)**

_____is slow to warm-up to/or change to a different activity.

_____avoids eye contact, turns away from human face, or prefers objects and toys.

_____is excited or restless when in a crowded, bustling setting, supermarket, or restaurant.

_____dislikes hair/face washed or haircuts.

_____touches everything in sight.

_____gets car sick.

_____is over/under-reactive to such noise as: loud, high, or pitched noise. **(circle)**

_____is easily startled or jumpy.

_____is slow moving/lethargic.

_____gets hyperactive or under-active. **(circle)**

_____is oversensitive to bright lights or new and striking visual images. (such as colors or shapes). **(circle)**

_____does not interact back and forth. (has few back and forth exchanges.)

_____dislikes being dressed or undressed.

_____is sensitive to certain clothes.

_____still puts things in mouth. Explores objects with mouth.

3. **Motivation & Energy** *(Mark with an X only if statement is true or mostly true.)*

My child...

_____hardly shows any facial expression.

_____is often sad.--

_____is moody (often goes rapidly from happy to sad or angry) without apparent reason

_____is over-talkative & chatty.

_____has decreased alertness.

_____spends much effort with little return.

_____has difficulty staying on or finishing assigned tasks.

_____runs out of energy.

_____goes from activity to activity without completing one.

_____is inhibited, anxious, shy.

_____seems confused--"in a fog".--

_____gets bored easily.

_____interrupts frequently

_____has few interests.

_____fails to finish things he/she starts.

_____is easily frustrated.

_____needs frequent reward changes.

_____is hard to reinforce with rewards.

_____has a short attention span (is easily distracted). **(Circle)** how long he/she can sit in the following activities:.

2 5 10 15 30 minutes playing one activity.

2 5 10 15 30 minutes watching videos or TV.

2 5 10 15 30 minutes being read to.

_____seems extremely impulsive compared to other children (doesn't think before acting).

_____is fearless--takes chances that are unsafe.

4. Hearing & Talking *(Mark with an X only if statement is true or mostly true.)*

My child...

_____has difficulty understanding or remembering what he/she hears.

_____needs complicated directions repeated.

_____often "tunes things out" --especially what is heard.

_____talks very loudly, even during normal conversations.

_____frequently doesn't respond when called from other rooms.

_____frequently turns the same ear in the direction of the sound.

_____confuses or misunderstands words that have similar sounds but are different (like top/tap, track/tack).

_____repeats or echoes previously heard words or phrases.

_____doesn't ask questions.

_____can't retell a short story.

_____is hard to understand (stutters, repeats words, talks fast, slow, or interruptedly). **(circle)**

_____has trouble learning words in songs, nursery rhymes, etc.

_____has unusual speech tone, rhythm, or voice.

_____struggles at putting ideas into words or finding the right words to use.

_____has difficulty using correct word arrangements. like me/I, her/she, him/he.

_____has difficulty telling about recent events

_____has little conversation ability.

5. Thinking, Remembering & Playing *(Mark with an X only if statement is true or mostly true.)*

My child...

_____has simple, repetitive, monotonous play.

_____has little creativity or pretending as in playing with cuddly objects, or plays with toys only one way.

_____plays inappropriately with toys: throws, breaks, or uses them in the wrong way.

_____has trouble using gestures: waving, clapping, pointing or using hands when talking. **(circle)**

_____has trouble sorting or classifying similar or same things. (colors, shapes, objects, ideas).

_____is illogical or confused. It is hard to understand his/her thoughts.

_____has trouble catching on to things, or is slow to understand.

_____doesn't seem to learn from mistakes.

_____has trouble finding personal belongings or remembering where things are.

_____has trouble remembering past experiences.

_____has a "style" to help remember (repeating things, "seeing" things, talking to self).

_____prefers videos to action play.

_____plays same videos over and over.

6. Vision, Ordering & Space *(Mark with an X only if statement is true or mostly true.)*

My child...

_____has difficulty with ordering, ideas or objects, motor actions, words, &/or putting ideas in a row. **(circle)**

_____has problems organizing in the following areas: time, space, materials

_____has difficulty cutting with scissors.

_____has little interest in puzzles or such toys as "legos".

_____misjudges objects and things while reaching. Spills or has "accidents".

_____has trouble working with small objects like buttons, zippers, fasteners.

_____eats in a sloppy manner.

_____knows prepositions like behind, under, next to, in front.

_____holds his/her head close to paper when writing/reading/coloring.

_____tilts head while reading, writing, coloring, or drawing.

_____has poor memory seeing or visualizing things.

_____has a poor sense of direction--gets lost easily..

_____draws simple pictures (stick figures, with no detail).

_____has/had trouble keeping inside the lines when coloring.

_____knows right from left.

7. Motor Coordination *(Mark with an X only if statement is true or mostly true.)*

My child...

_____handles self poorly on playground as with slides, swings, monkey bars. **(circle)**

_____is unable to ride a bike or tricycle.

_____falls and trips frequently; is clumsy.

_____is awkward when running; loses balance.

_____avoids games or activities involving catching, throwing, hitting, or kicking a ball.

_____has poor timing (swings a bat after ball goes by, catches before or after ball arrives).

_____has trouble skipping or hopping.

_____has a slumped body posture--leans on a hand or an arm when doing table top activities.

_____has to have things his/her way.

_____compared to his peers he/she is not as strong, i.e. can't run as far, can't pull on monkey bars.

8. Caregiving/Cooperation *(Mark with an X only if statement is true or mostly true.)*

My child...

_____is very controlling (bossy).

_____does not respect others' privacy/crosses others' borders.

_____gets distressed when separated from parent(s).

_____argues with me/refuses to do things I expect of him at home.

_____resists efforts to stop his/her behavior.

Parent Feelings: *(Mark with an X only if statement is true or mostly true.)*

_____I have an established daily routine for eating, sleeping, play times, family time, etc.

_____No matter what I try, nothing seems to help my child's behavior.

_____I feel used up and burned out by my child.

_____My child causes me to worry excessively.

_____Toilet training and/or feeding time is horrible for both me and my child.

_____We have constant battles or power struggles.

_____It is difficult getting my child to bed and keeping him there.

_____I feel inadequate trying to comfort my child when he has been upset.

_____I tend to forget my early childhood relationships with my mother.

_____I seem preoccupied thinking how wonderful and ideal my mother is (was).

_____I feel that I am overly involved or very protective of my child.

_____My child makes me very angry; sometimes I lose control verbally or physically. **(circle)**

_____It seems there is no one to whom I can go for help.

_____Sometimes I worry about our discipline being too harsh or physical.

_____My child likes creative, imaginative play.

_____I have clear expectations for my child's social, school, and family behaviors.

_____I've been depressed or feel angry much of the time. **(circle)**

_____I remember little nurturing, warmth, or being cared-for when I grew up.

9. Family *(Mark with an X only if statement is true or mostly true.)*

My child...

_____has no pets.

_____rarely eats breakfast.

_____fights with brothers and sisters.

_____does better in a one-to-one situation.

_____is a discipline problem.

How many children in your family?_____Which number is this child?_____

As a family...

_____I have the support of a spouse or partner.

_____Our monthly income is_____.

_____Consequences or punishments for breaking the rules are given out consistently (always the same) by both parents.

_____Both parents agree on what the rules are for the children.

_____Both parents agree on what the consequences are for breaking rules.

_____Family values and child expectations are consistently supported by both parents.

_____Family rules are posted in the house.

_____Family rules are talked over clearly.

_____Friends or relatives ask us not to visit due to this child's behavior.

_____I/we live close to relatives.

_____I/we visit together and/or call often.

_____I go to the following person(s)for support:_____

_____I/we have State or other assistance. **(circle)**: SSI, Medicaid, AFDC, food stamps, legal, "reduced lunch", HEAT program, food bank, other.

_____My/our family is active in an organization. **(circle):** PTA, church, Scouts, sports, karate parent support group (list name)_____, any volunteer work, other.

_____Other agencies are involved with our family. **(Circle)** which one(s) apply: Social Services, Mental Health, court, family worker, other
Please give names and phone numbers:_____

_____There are others outside the family who care about my child, who are special, and who spend time with my/our child frequently. Name & ph#:_____

(Circle) what your family has: telephone washer/dryer, TV, VCR, Nintendo own/rent home car gun(s)

Number of moves in this child's life_____

My child... *(Mark with an X only if statement is true or mostly true.)*

_____was hurt by a psychological or physical trauma or hurtful event.

_____has brothers or sisters with serious problems.

_____has had other life experiences or stressful events which have had adverse effects on him/her.

Please **(circle)** any of the following which occurred in your family in the last 12 months:

moved to new home	parents separated/divorced	family member(s) hospitalized
child entered new school	death in family/relation to this child	financial difficulty
new child in family	job loss(es) or starting new job(s)	gang membership
serious family arguments	other siblings doing poorly in school	other catastrophes
violence in the home	violence in neighborhood	too many hassles

Please **(Circle)** family stress level:	Present:	Little	1	2	3	4	5 Much
	Last 6 months:	Little	1	2	3	4	5 Much

10. Coping-Defending Responses

My child... *(Mark with an X only if statement is true or mostly true.)*

_____lives in a fantasy/unreal world.

_____is argumentative.--

_____acts passive--no initiative.

_____has poor judgment.

_____adjusts (adapts) poorly after change.

_____blames others/denies behavior.

_____is involved with drugs/alcohol.

_____runs away.

_____lies frequently.

_____is self-abusive.

_____is preoccupied with hand washing, cleanliness, or ordering of things.

_____is unable to take care of him/herself.

_____cries easily when scared/criticized.

_____gets sleepy or sleeps soon after being scolded.

_____overeats/undereats when stressed or disciplined.

_____acts very immaturely for his/her age.

_____has difficulty calming self when upset.

(Circle) only those self-help areas that your child **can't do**:

wash hands with soap	tie shoes	buy something with money	pour drinks
memorize street address	brush teeth	cut food with knife	help with chores
cross the street	dress self	toilet train	

When your child is upset what works to calm him/her down?

_____

_____

How does your child react to disappointment?

_____

_____

How long does it take to get calm again after disappointment? **(Circle)**

5 min 15 min 30 min 1 hr longer

11. Feelings and Social Relations

My child... *(Mark with an X only if statement is true or mostly true.)*

_____feels persecuted or picked on.--

_____feels "mixed-up".

_____feels unusually guilty.--

_____shows inappropriate affection and feeling for the situation.

_____is secretive.--

_____rarely shows feelings.

_____thinks about sex too much.

_____has many fears.--

_____is very self-conscious.

_____is aggressive.

_____sets fires.--

_____is seductive.

_____has a bad temper.

_____gets angry most of the time.

_____often destroys things.

_____gets easily frustrated.

_____thinks about sex too much.

_____acts out sex behaviors.--

_____is critical of self—puts self down.

_____is tense, anxious or nervous.--

_____hoards or collects things.

_____has obsessive, compulsive behavior.

_____is withdrawn, likes to spend a lot of time by himself/herself.--

_____is shy, timid, has few friends.

_____has more younger or older friends than friends of own age.

_____is depressed, has low moods.

_____will go to anyone, including strangers.

_____doesn't like praise--can't accept positive feedback.

_____plays with sexual body parts too much.

_____has fewer friends due to negative bossy, or annoying behavior.

_____disturbs others: teases, provokes fights, interrupts, wants attention.

_____physically strikes back at teasing peers.

_____displays physical aggression toward objects or persons.

_____speaks to others in an impatient or cranky tone of voice.

_____gets picked-on or bullied fre□uently.

12. Awareness of Others *(Mark with an X only if statement is true or mostly true.)*

My child...

_____seems to have no conscience; has little guilt.--

_____is cruel to animals.--

_____is involved with the courts/law.

_____is a gang member or associates with gang members.

_____steals things at home/store **(circle)**.

_____is unconcerned about feelings of others or seeking approval.

_____identifies with "rules" in our home (e.g., "Daddy said...", "Mommy said...").

_____can't take on others' points of view.

_____shows little empathy or sensitivity for others.

_____has difficulty following rules or staying within limits.

_____has problems sharing or taking turns.

_____lacks manners.

13. Rights & Needs

My child... *(Mark with an X only if statement is true or mostly true.)*

_____has few interests, hobbies, or talents.

_____has few outside activities:
(circle those not attended)
clubs, sports, church.

_____lacks self-esteem/self-worth.

_____feels inferior.

_____has loss of his/her spirit/enthusiasm.

_____does not respond to limit setting, controls or discipline.

_____is highly dependent/is "clingy' or "hangs on".

_____lacks confidence, needs frequent reassurance.

_____doesn't have immunizations up-to-date.

_____doesn't use a seatbelt.

(Circle) any of the following you feel the family has more need for:

religious worship

family worth & esteem

medical care, a doctor

child care

recreational outlets

discipline & limit setting

early intervention preschool

information about my child's condition

intimate friends

dental care

counseling

toys/books

needs of living (food, housing, utilities) **(Circle)**

summer program

coordinating child's care

controlling anger

money for bills

kids doing more chores

health insurance

transportation

feeling safe

parent support group

alcohol/drug treatment